Money Follows the Person
Rebalancing Demonstration Grant
Operational Protocol
2007-2011

State of North Carolina
Department of Health and Human Services

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Project Introduction

In May 2007, the Center for Medicare and Medicaid Services (CMS) awarded North Carolina a grant through Money Follows the Person Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. North Carolina intends to use the funds to develop a roadmap for rebalancing Medicaid long-term care delivery system. The goal is to move forward with a long term cares system that provides an even greater array of home and community-based services and supports designed to promote choice and independence for individuals who are aging with care needs, or have physical, mental, or developmental delays. This goal will be carried out through the following demonstration objectives.

Objective 1: Increase the use of home and community-based, rather than institutional, long-term care services.

In 2004, the State Legislature passed House Bill 1414, section 10.12(a) mandating the Department of Health and Human Services, Division of Medial Assistance to develop a pilot program to implement the Program for All-Inclusive Care for the Elderly. This is a community based program that provides unique managed care benefit for the frail elderly. The program operates an adult day health center and:

- Provides a comprehensive array of medical and social services at the center
- Arranges for all in-home and referral services that may be required by each enrollee, and
- Uses an interdisciplinary team to manage care and services for each enrollee.

Objective 2: Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, which prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

Objective 3: Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting.

North Carolina has experienced success with transitioning individuals from nursing facilities. In September of 2002, the Federal Centers for Medicare and Medicaid Services awarded North Carolina Division of Medical Assistance a three-year grant of $600,000 to develop and conduct a **North Carolina Nursing Facility Transitions Program** in collaboration with North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program. In July of 2005, Centers for Medicare and Medicaid Services approved a six-month no cost extension that extended grant-funded activities through March 29, 2006. As of December 31, 2005, a total of 86 individuals had been fully transitioned from nursing facilities to community living as a direct result of intervention managed, coordinated, and funded under this grant. In addition, there were an additional 12 to 15 active cases expected to result in transitions during the period January 1 to March 29, 2006. The average length of time transitioned individuals remained in the community was 287 days at the time program evaluation data was reported.

Objective 4: Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous quality improvement in such services.

The NC Department of Health and Human Services has received two grants from the Centers for Medicare and Medicaid Services that are working toward transformation of the long term services and supports system. The Systems Transformation Grant focuses on three goals: Improved Access to Long-Term Support Services; Increased Choice and Control; and Transformation of Information Technology to Support Systems Change. Some of the key outcomes and products resulting from this proposal include:

- Implementation of a statewide and centralized Information & Referral infrastructure that enables consumers/their families to locate up-to-date information on community resources, long-term service and support options, health issues, disease self-management, self-direction and person-centered planning via the web; and expansion of the Aging and Disability Resources Connections.
- Increased available options for self-direction and self management within DHHS; person-centered training curricula developed and used to train providers and direct care staff; person-centered thinking incorporated into DHHS processes.
- Development and implementation of: an Information Technology (IT) plan for nine Medicaid long-term service and support programs; a refined IT model for case management; an automated screening, assessment and planning system for adult care homes and Personal Care Services; and an enhanced quality monitoring/utilization management program with specifications for analytic tools.

The Person-Centered Planning Implementation Grant will further support the person-centered initiatives in the Systems Transformation Grant. Through this grant, DHHS will be able to provide more training as well as work with organizations interested in improving their leadership capacity to support person-centered thinking throughout their organizations.

A Real Choice Systems Change grant, Integrating Long-Term Supports with Affordable Housing, was awarded to North Carolina in September 2004 and ran for three years. It was funded through the Federal Centers for Medicare and Medicaid Services and was a partnership among CMS, Department of Health and Human Services, and the North Carolina Housing Finance Agency. The major goal of the grant is to help implement the Department of Health and Human Services partnership in the Low-Income Housing Tax Credit program. It requires that 10% of all low-income housing tax credit units be set aside for people with disabilities. Since 2002, about 500 tax credit housing units have been funded specifically for people with disabilities.

Case Studies

Trish Farnham Brown will provide for DD – received; will revise based on additional info in OP
physically disabled – 3/12/08 asked Fred Johnson; he and Ryan Pinioin will submit by 4/11/08
Need one for elderly – 3/20/08, Denis Rogers will work on this. Submitted 3/28/08
Need one for MI – 3/20/08, Vivian Leon; 4/1/08, Vivian suggested Bonnie Morrell –emailed her the request 4/1/08; will submit 4/11/08.

Case Study for the Elderly

Background

Mrs. Sergor, age 65, has been residing in the Buncombe County Nursing Home for the past ten months. Mrs. Sergor and her husband moved to the western part of North Carolina from California when her husband retired eight years ago. Mrs. Sergor's husband died suddenly a year and a half ago. She has no relatives living in North Carolina but she has several friends from church who visit often. Mrs. Sergor had a hip replacement at Asheville Hospital due to rheumatoid arthritis. She transferred to Buncombe County Nursing Home for expected two week rehabilitation after her surgery. While she was there she suffered a stroke leaving her paralyzed on her left side. Mrs. Sergor received extensive rehabilitation and improved but still needs assistance in bathing, dressing and getting in and out of a bed or chair. Mrs. Sergor continues to need skilled level care. She was determined eligible for Medicaid three months ago. Mrs. Sergor felt she was too young to be in a nursing facility.

Process of participant identification

A Regional Long Term Care Ombudsman along with a MFP transition coordinator was visiting the nursing home to speak with the resident council about Money Follows the Person Grant and residents' rights. Mrs. Sergor attended the council meeting and read the information given out to the residents and staff on Money Follows the Person. Mrs. Sergor decided she wanted to make the move back into the community so she contacted the MFP transition coordinator through their toll free number and requested assistance. Mrs. Sergor expressed a desire to move back to her former neighborhood.

Processes prior to the transition

The MFP transition coordinator set up an appointment to visit with Mrs. Sergor at the facility. The MFP transition coordinator explained the program in more detail and how the Money Follows the Person Grant could assist her in transitioning out of the nursing home into a place of her own. The MFP transition coordinator explained the different living arrangements and what service options may be available to her. They also explained that some services received in a nursing home may not be available to her in a home setting. With Mrs. Sergor's approval the MFP transition coordinator arranged a meeting with Mrs. Sergor, the social worker and/or the director of nursing at the facility to review her information from the Resident Assessment Instrument (RAI). Reviewing the RAI with facility staff will help determine the medical support, personal care and any other current medical supports needed to assist Mrs. Sergor's in the community.

The MFP transition coordinator began a transition plan with Mrs. Sergor by discussing the roles of friends, housing options, health care, personal assistance, home adaptations or assistive technology, transportation, finances, her social and faith activities and volunteer or employment options. The MFP transition coordinator briefly explained CAP/DA and CAP/Choice. The coordinator assisted Mrs. Sergor in setting up an appointment with the CAP case manager in the county who would provide more detailed information.

Mrs. Sergor expressed a desire to move into a housing situation where two meals a day would be provided. There is a senior congregate housing apartment complex in her former neighborhood. The housing complex is close to her church. Some of her friends from church recently moved into the same senior housing complex. The rent is based on income so it is an affordable option. The housing complex provides transportation for the tenants to the grocery store and shopping malls. The housing manager will assist in arranging trips for medical appointments. The MFP transition coordinator assisted Mrs. Sergor in contacting the senior housing complex.

Processes during the actual transition into community life

The MFP transition coordinator met with Mrs. Sergor and others to develop a plan to ensure the success of her transition. Because of Mrs. Sergor's extensive functional and support needs the transition coordinator informed her of community based organizations that might help resolve problems that might arise during her transition period.

There is a two month waiting list in this county for a CAP/DA slot and a waiting list for housing. Over the next two months the transition coordinator will assist Mrs. Sergor in securing furnishings for her new home as well as providing deposits for rent and connecting fees for utilities through the Money Follows the Person one time transition expenses.

The CAP/DA waiver provides services and supports to individuals who meet the nursing facility level of care who can safely and effectively be served in the community. CAP/DA will provide in-home aide services and pay for a personal emergency response system for Mrs. Sergor.

Mrs. Sergor expressed a desire for a motorized wheelchair so she would have more mobility and be able to perform volunteer work at her church which is across the street from her soon to be new home. With Mrs. Sergor's permission the MFP transition coordinator contacted the church and other community resources to raise funds to assist Mrs. Sergor in obtaining a motorized wheelchair.

The day arrived when a studio apartment became available and a CAP/DA slot in her county became available. The MFP transition coordinator worked closely with Mrs. Sergor and the facility social worker to ensure that her discharge from the nursing home progressed in an orderly way, that Mrs. Sergor was able to find a doctor in the community, and she had a sufficient supply of medications to last before her visit to her new doctor.

Processes when the individual has been transitioned into a home and community based program

The MFP transition coordinator met Mrs. Sergor when she arrived at her new apartment. The apartment had a small kitchen that was stocked with groceries and her clothes were in her bedroom. The MFP transition coordinator and the home health agency made sure the in-home aide reported to work at the same time Mrs. Sergor moved into her new place. Mrs. Sergor was given the telephone numbers of the MFP transition coordinator and the home health agency if she had any problems or questions.

The MFP transition coordinator will visit Mrs. Sergor once a week for a month to see how she is adjusting. The second month the MFP transition coordinator will visit her two times and the third month one time. On her visits to see Mrs. Sergor she observed that Mrs. Sergor was happy to be able to visit with her friends and enjoyed participating in activities at the senior apartment complex and volunteering at her church.

One day she did have a challenge with her in-home aide that provided her personal care services. The in-home aide failed to show up as scheduled. She tried to transfer herself to the wheelchair but her arms were a little weaker than usual and she panicked. Mrs. Sergor remembered her emergency response button around her neck and pushed the button. The emergency response system alerted the home health agency and a neighbor. The neighbor had a key, was able to enter into the apartment, and sat with Mrs. Sergor until the home health agency sent a in-home aide.

Benchmarks

The North Carolina Money Follows the Person Project will measure five benchmarks – two which are required by CMS and three developed by the State. Given the possible changing needs of the population and understanding that the benchmarks may need to be revised or edited once implementation starts, it is anticipated these could change. North Carolina will assess and provide revised benchmark information to CMS as needed.

1. ***The projected number of eligible individuals in each target group to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration***

Projected number of transitioned participants by year and population						
	Elderly	**MR/DD**	**Physically Disabled**	**Mentally Ill**	**Dual Diagnosis[1]**	**Total**
2008	1	6	8	2	4	21
2009	5	25	51	6	16	103
2010	7	61	61	15	41	185
2011	9	80	82	19	53	243
Total	22	172	202	42	114	552

2. ***Qualified expenditures for Home and Community Based Services during each year of the demonstration program***

Federal Fiscal Year	Qualified Home and Community Based Services Expenditures	Increase in Expenditures	% Increase from Previous Year
2008	$108,891		
2009	$2,415,755	$2,306,764	2116.5%
2010	$5,246,328	$2,830,573	117.2%
2011	$8,839,079	$3,592,751	68.5%
Total	$16,610,053		

The following additional benchmarks have been selected by the State

1. Establishing a trusted, visible, and reliable system for accessing information and services by a date certain (i.e., the establishment or expansion of one-stop shops),

The North Carolina Department of Health and Human Services, Division of Aging and Adult Services, received an $800,000 three-year grant to develop two Aging and Disability Resource Center pilot sites in 2004. The term "Aging and Disability Resource Centers" has been changed in North Carolina to "Aging and Disability Resource Connections" to reflect the building of decentralized, no wrong door models in North Carolina. The two pilot sties are located in Forsyth and Surry counties. The purpose of the Aging and Disability Resource Centers is to

[1] Estimated 35% of MR/DD/MI population will have dual diagnosis

provide information on the full range of long term care options and to streamline access to long term care services and supports at a uniform point of entry.

In October 2006, North Carolina Department of Health and Human Services, Office of Long-Term Services and Supports, received a Systems Transformation Grant from CMS. One of the three selected goals is "Improved access to long term care support and services: Development of a one-stop system." Funds were provided under this grant to expand Aging and Disability Resource Connections. Activities under this grant and activities for Aging and Disability Resource Connections expansion under funding from the Administration on Aging were combined under the Office of Long Term Services and Supports for Department of Health and Human Services. The goals of Aging and Disability Resource Connections are to:

- Streamline and simplify access to long-term services and supports in order to ensure each individual's need for services is determined and addressed,
- Maximize consumer choice and provide services in a consumer friendly manner, respecting and ensuring the dignity of all served, and
- Creating a more balanced system of long-term services and supports to include more home and community-based services.

Aging and Disability Resource Connections will also be able to provide counseling for long term service options.

At this time, there are two operational Aging and Disability Resource Connections. The benchmarks provided in the table below summarize the expected expansion of Aging and Disability Resource Connections and the increase in the number of individuals served by these centers.

North Carolina has also developed a web-based information and referral system called NCcareLink. This system includes information about services and supports available statewide and will be utilized in all the state's Aging and Disability Resource Connections to assist individuals in identifying long term care services and programs in their part of the state.

Benchmark	**Federal Fiscal Year**				
	2007-08	**2008-09**	**2009-10**	**2010-11**	**Total**
# of Aging and Disability Resource Connections in North Carolina	2	6	6	6	6
# of Individuals served by Aging and Disability Resource Connections	6,594	13,188	19,782	20,474	60,038

Ann Eller indicates the numbers need to be checked – she provided the #'s in red 4/4/08.

Aging and Disability Resource Connections will also have a qualified screener who can utilize the web-based Medicaid Uniform Screening Tool to assist individuals in determining what Medicaid long term care services and supports may be available. This uniform screening program is described in Additional Benchmark #2 below.

2. Establish processes for screening, identifying, and assessing persons who are candidates for transitioning to the community that are put into use in the general Medicaid program beyond recruitment for the Money Follows the Person demonstration.

The Division of Medical Assistances and Division of Mental Health, Developmental Disabilities and Substance Abuse Services will employ a variety of methods to identify individuals in various treatment settings who would like to transition to community care. These methods are summarized by population group and facility setting below. Additionally, individuals are encouraged to use self-advocacy as a means of expressing an interest and desire in transitioning to community care. Even though the benchmarks noted here speak towards instruments and/or tools and assessments, individual self-advocacy will be valued and honored as a means of identification of those desiring to move from an institution or facility into the community. Assessment(s) of the individual's needs for transitioning will be implemented as outlined in this Operational Protocol after an individual expresses an interest.

Population Group
Individuals who are elderly or physically disabled who have resided in a nursing facility for at least six months.

The following chart indicates the number of individuals to be identified via various tools and/or organizations.

Federal Fiscal Year	Individuals identified by:				
	Medicaid Uniform Screening Tool	Centers for Independent Living	Long-Term Care Ombudsmen	Voc. Rehab Independent Living Rehabilitation Program	Total
2008	0	5	2	2	9
2009	2	28	14	12	56
2010	3	34	17	14	68
2011	5	46	23	17	91
Total	10	113	56	45	224

In August 2006, North Carolina Division of Medical Assistance entered into a two year agreement with Electronic Data Systems Corporation to develop and implement a web-based Medicaid Uniform Screening Tool for Medicaid long-term care programs, services, and supports. This tool provides a comprehensive screening of individuals applying for Medicaid long term care services that includes evaluation data elements relating to medical conditions and needs, prescription drugs, functional limitations, socio-demographics, mental illness, mental retardation and related conditions issues and needs (i.e., Preadmission Screening and Annual Resident Review Screening and Level II Evaluations), cognitive status, mood and behavior, orientation

and interpersonal functioning, home environment and caregivers to name some of the most relevant. The Medicaid Uniform Screening Tool, through programmed internal logic, will select three Medicaid programs that are a best fit for the individual and recommend one program as best-fitting of the identified options.

The Medicaid Uniform Screening Tool incorporates level of care reviews and pre-admission screening (as required under the federally-mandated Preadmission Screening and Annual Resident Review regulations) for mental illness, mental retardation, and related conditions. Screened individuals who appear to have treatment needs relating to these conditions are referred for a full Level II mental illness, mental retardation and related conditions evaluation.

The Medicaid Uniform Screening Tool will support nursing facility and special care unit (for Alzheimer's or related disorders) transitions in five ways. Specific elements within the screening domains will:

1. Record the applicant's preference to receive services in a facility, or in the home/community setting;
2. Evaluate the applicant's home environment and availability for capable and willing caregivers;
3. Provide information about whether the applicant can live safely in the community;
4. Determine if the individual has the requisite cognitive capacities, orientation, and interpersonal functioning capabilities for self-directed and chronic disease self-management programs or who has a representative who has the capacities and willingness to assist the person in self-direction/self-management; and
5. Provide the applicant a choice of program and service options based on the level of care required, preferences, and available programs, services, and supports.

The screening tool will also help to determine if a nursing home residency is likely to be short or long term. Individuals requiring only short-term stays in nursing homes will be contacted by a professional or volunteer associated with one of the Money Follows the Person participating agencies/organizations when the individual has been in the nursing home the requisite six months. Transition plans will be developed for those that want to return home and receive home and community-based services.

Between September 2002 and March 2006, North Carolina conducted a successful Nursing Facility Transition Program under a CMS grant. The grant enabled the state to demonstrate a successful collaboration between state agencies, regional non-profit organizations, and local agencies and groups. In particular, the North Carolina Division of Vocational Rehabilitation's Independent Living Rehabilitation Program and the Centers for Independent Living played key roles in identifying individuals for transition. Long-term care ombudsmen were also effective in identifying and referring nursing home residents interested in transitioning to community care. The agencies and organizations are committed to participating in these transition activities under the Money Follows the Person Demonstration.

All individuals in this population group will receive an independent living evaluation before a transition plan is developed and implemented.

Population Group

Individuals with skilled nursing requirements and mental illness who have resided in nursing homes for at least six months.

The following chart shows the number of individuals to be identified through the various tools and/or organizations.

Federal Fiscal Year	Individuals identified by:		
	Preadmission Screening and Annual Resident Review	Through Centers for Independent Living, Independent Living Rehabilitation Programs, and Ombudsmen	Total
2008	1	1	2
2009	7	2	9
2010	18	5	23
2011	23	6	29
Total	49	14	63

Federal regulations require that all individuals requesting admission to a nursing facility be screened for mental illness, mental retardation, and related conditions. This process will be included in the North Carolina Medicaid Uniform Screening Tool. Currently the Preadmission Screening and Annual Resident Review contractor maintains records of all previous screening and follow-up of Level II mental illness, mental retardation and related conditions assessments. Preadmission Screening and Annual Resident Review screening will be the principle source of information to identify individuals residing in nursing facilities with mental health diagnoses. Other individuals may be identified by agencies and organizations involved in monitoring long term care services (i.e., Ombudsmen) and providing transition-related services (i.e., Centers for Independent Living and Vocational Rehabilitation's Independent Living Rehabilitation Program).

All individuals in this population group will receive an independent living evaluation before a transition plan is developed and implemented.

Population Group
Individuals with developmental disabilities who have resided in state Developmental Day centers and public and private Intermediate Care Facilities/Mental Retardation for at least six months and individuals who have resided in state and private psychiatric facilities for at least six months.

The following chart shows the number of persons to be identified annually via the annual person-centered planning meetings.

Federal Fiscal Year	Identified via Annual Person-Centered Planning Meetings
2008	11
2009	42

2010	105
2011	137
Total	295

Each year, individuals receiving Medicaid and state-funded services for developmental disabilities and mental illness, with their families, guardians and/or caregivers, participate in an annual "Person-Centered Planning Meeting." If the resident or resident's family or guardian indicates that they are "in favor of" or "not opposed to" community living, the resident is placed on a list and transitioned when housing and services become available.

3. Expansions to, and improvements in, health information technology (i.e., progress directed by the state to build systems that accommodate the business needs of multiple organizations that serve the targeted populations).

Benchmark	Federal Fiscal Year				
	2008	**2009**	**2010**	**2011**	**Total**
# of individuals screened through Medicaid Uniform Screening Program[2]	26,500	106,000	114,500	92,700	339,700
# of "hits" on North Carolina CareLink	12,000	15,000	20,000	20,250	67,250

North Carolina Division of Medical Assistance has planned for and is in the processing of developing two web-based automated long term care program management tools.

The Medicaid Uniform Screening Tool, described above, will make it faster and easier for individuals to be approved for Medicaid long term care services and supports. This system will also support facility transitions, consumer self-directed programs, and chronic disease self-management programs. Since this tool is Internet-based, multiple organizations will have access to data and information required to fulfill their roles in the Medicaid long term care program admission process.

[2] Based on historical data

Participant Recruitment and Enrollment

Persons who are eligible for home and community based services (CAP-MR/DD, CAP/DA, CAP/Choice) and reside in an eligible institution will be eligible to participate in North Carolina's Money Follows the Person Demonstration grant. The following provides a description of the target populations within North Carolina that will be transitioned during the duration of the Money Follows the Person Demonstration Grant project, as well as the recruitment processes utilized for those target populations.

The target populations selected for transition include aging individuals with care needs and/or disabilities who have been residing in nursing facilities for a minimum of six months; individuals who have been diagnosed with a mental illness and who have resided in nursing facilities or special care units (for Alzheimer's or related disorders) for a minimum of six months; individuals who have been residing in private Intermediate Care Facility-Mental Retardation facilities or public Intermediate Care Facility- Mental Retardation facilities (developmental centers) for a minimum of six months; and individuals with mental illness who have been treated in a state or private psychiatric facility for a minimum of six months and who are eligible for Medicaid one month prior to transition.

A detailed person–centered plan[3] (which includes a transition plan) is required to be completed for each individual who qualifies for transition through the Money Follows the Person Demonstration Grant project. Factors to be considered in the transition plan will include:

- Medical issues and resources to meet the identified needs
- Behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- A clear and well documented crisis plan that addresses not only intervention techniques but the prevention processes as well
- Residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members/guardians and informal supports.

Please refer to Marketing, Outreach, and Education section for additional information.

Selection Process

During North Carolina's first year of Money Follows the Person demonstration grant, there will be a limited number of months to transition twenty-one individuals. As a means of ensuring success, individuals meeting the following discharge potential criteria (after being determined eligible) will be served in this order:

[3]The use of person–centered planning principles is being encouraged in all divisions within North Carolina Department of Health and Human Services for their day-to-day operations and use in policy development. Participation of agency's staff in developing these principles has truly been effective in helping the Department of Health and Human Services to make policy changes. This information was distributed in August 2007. It will take time for systems to change where this terminology is used consistently and across the board in all divisions. In the meantime, 'plan of care' will be seen in written documentation until such revisions and/or amendments are made. Specifically, within this document, both phrases will be seen and the reader is advised to understand there will be a gradual, systematic change to the use of 'person-centered planning' and the principles around this important concept.

- *None:* Consumer is interested and has minimal/limited barriers, or barriers can be easily overcome, AND guardian or legal representative (if there is one) is supportive of discharge
- *Limited:* Consumer is interested, but has barriers that will take some time to resolve OR guardian or legal representative (is there is one) is not supportive, or aware, of options available upon discharge.
- *Moderate:* Consumer is not interested, but has barriers that can be overcome and guardian or legal representative (if there is one) may or may not be supportive
- *Significant:* Consumer is unable to overcome the barriers to discharge (i.e., specific medical issues that cannot be met in settings that the consumer is willing to consider with services available informally, in the community and under home and community- based services) OR consumer cannot express interest because of severe cognitive limitations and guardian or legal representative (if there is one) is not interested in another setting.

In all cases, the individual's family will be considered if the individual has provided permission for the family to be involved.

The transition manager will be a State employee who oversees, coordinates, and manages the individuals from agencies assisting clients as they prepare for transition to the community. The transition manager will have experience and skills in transitioning individuals from facilities and institutions into the community. The transition manager will be located in the Division of Medical Assistance office in Raleigh, North Carolina. In each community, staff and advocates from Centers for Independent Living, Division of Independent Living Rehabilitation Program, Association of Self Advocates, Real Advocates Now Emerging, and Ombudsmen will work directly with individuals who express a desire to transition out of a facility. The transition manager will serve as a resource in locating services, etc.

Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility

To qualify for transition, individuals must be eligible for Medicaid one month prior to transition and have resided in the facility for a minimum of six months. The target region for this population is the entire state.

Individuals expressing a desire and interest to transition out of a nursing facility will review and discuss with their families/guardians and the transition coordinator, the information from the Minimum Data Set or any other assessment tool used by the facility to determine the medical support, personal care, and other supports available to the meet the individual's needs for transitioning to a qualified residence.

Nursing home transition coordinators will facilitate the process of identification through contact with specific nursing homes within their geographical region and with the Regional Long Term Care Ombudsmen. The agency's transition coordinators will provide information to consumers and their families/guardians/caregivers to ensure an understanding of the Money Follows the Person Demonstration Grant project and the target population focus. This information will be provided in written and verbal form and will include information regarding the project itself, community residential options to nursing home placement, and support services available to maintain the individual within the community. Assessments are person-centered and will accurately reflect the individual's desire with input from the individual's guardian/legal representative, when applicable. Input from the individual's family will be considered if the individual has provided permission for the family to be involved.

Individuals Who Are Residing in Private Intermediate Care Facility-Mental Retardation Facilities or State-operated Intermediate Care Facility-Mental Retardation Facilities (Developmental Centers)

During the first year of the demonstration (why only during the first year? – it was suggested Vivian Leon could provide clarity), individuals residing in the state-operated developmental centers and private Intermediate Care Facility-Mental Retardation facilities who have indicated through a survey (**Attachment A**) or at the individual's annual person-centered planning meeting an interest in community living will be contacted along with the individual's guardian, when applicable, and the individual's family if the individual has provided permission for the family to be involved and informed about the Money Follows the Person Demonstration Grant project. (Is Attachment A only to be used by state ICF-MRs? Not used by private ICF-MRs?) Each individual will be surveyed using a standard set of four questions (**Attachment A**). (Stakeholders Advisory Group suggested revising to be more consumer friendly (along with Attachment B) The surveys will be administered by developmental center staff (Stakeholders Advisory Group suggest it be done by individuals outside of the institution/facility). The transition coordinator will provide information to individuals surveyed and their guardians regarding the Money Follows the Person Demonstration Grant project and their choice of community placement. This information will be provided both in written and verbal form and will include information regarding the project itself and community residential options to institutionalization, as well as services and supports available in the community that can be used so that the individuals is able to remain within the community. Those individuals and their guardians (or family members with permission) who express an interest and desire to transition to the community will be the focus of the transition process during the first year of the demonstration (2008).

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

Primary participants from state-operated psychiatric hospitals will be children and adolescents ages 6 through 17 who have been being treated for a duration of six months or longer. Social workers at each hospital (Cherry, Broughton, Dorothea Dix/John Umstead/Central Regional hospitals) will identify individuals who meet the following criteria:

- Ages 6 through 17
- Hospitalized for 6 months or more
- Medicaid eligible
- Residents of North Carolina
- Ready for discharge

The psychosocial assessment completed by the social worker and the discharge plan developed by the treatment team, in conjunction with family/guardian and community representatives, will be used to identify the most appropriate level of services and supports that the individual needs to transition to the community.

Hospital social workers will have received information from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services about Money Follows the Person and will share the information with the child/adolescent and his/her family/guardian. During the development of the discharge plan, the child/adolescent, planning team, family/guardian, and community representatives will determine if the individual will be a participant in the Money Follows the Person Demonstration Grant project.

Qualified Institutional Settings

Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility
Qualified institutional settings include skilled nursing facilities and special care units (for Alzheimer's or related disorders) throughout the State.

Individuals Who Are Residing in Private Intermediate Care Facility-Mental Retardation Facilities or State-operated Intermediate Care Facility-Mental Retardation Facilities (Developmental Centers)
Qualified institutional settings include private Intermediate Care Facility-MR facilities and state-operated facilities (developmental centers) throughout the State.

Note: The short-term specialty programs at the developmental centers are exempt from the Money Follows the Person Demonstration Grant project.

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital
Children/adolescents at each of the state-operated hospitals (Cherry, Broughton, Dorothea Dix/John Umstead/Central Regional hospitals) will be eligible. Each of the hospitals is certified as an Institution for Mental Disease (IMD).

Residency Requirements

Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility
The transition coordinator will be responsible for ensuring, through contact with the administrator and staff of the facility, that the individual assessed for transition to the community has been residing in the nursing facility for at least six months. This will be documented via an admission summary.

Individuals Who Are Residing in Private Intermediate Care Facility-Mental Retardation Facilities or State-operated Intermediate Care Facility- Mental Retardation Facilities (Developmental Centers)
The transition coordinator will be responsible for ensuring through the director and staff of the facility that the individual assessed to transition to the community has been residing in the developmental center or intermediate care facility for at least six months. This will be documented via an admission summary.

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital
Children and adolescents must be hospitalized for a minimum of six months to be eligible for participation in the Money Follows the Person Demonstration Grant project.

Process for Assuring Medicaid Eligibility

The transition coordinator will be responsible for ensuring that the individual who will be participating in the Money Follows the Person Demonstration Grant project continues to be eligible for Medicaid upon discharge from the facility. As applicable, hospital social workers, the developmental center's or Intermediate Care Facility-Mental Retardation group home's reimbursement office and nursing facility discharge planners work in collaboration with the

individual's local Department of Social Services in the specific county in which the individual resides to obtain documentation verifying Medicaid eligibility.

Enrollment

All individuals who wish to participate in the Money Follows the Person Demonstration Grant project, or if appropriate, the individual's legal guardian or representative, will be asked to sign a consent form (see **Attachment B**) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants and/or their family/guardian will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

Re-enrollment Policy

A Money Follows the Person participant who is re-institutionalized for a period *greater than 30 days* will be categorized as **disenrolled** from the program. However, a disenrolled individual may re-enroll in the program without re-establishing the 6-month institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant will still be eligible for Money Follows the Person services at the enhanced Federal Medicaid Assistance Percentage match. However, if the former participant remains in the qualified institution beyond 6 months, the participant will be defined as a "new" Money Follows the Person participant in terms of the Money Follows the Person services and the Federal Medicaid Assistance Percentage.

A former participant may re-enroll in the program after being re-evaluated and after having an updated Plan of Care. Once the individual is assessed to be appropriate for home and community based services services, a referral will be made to the case manager for development of the individualized Plan of Care that addresses any change in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of 30 days or longer, the re-institutionalized Money Follows the Person participant will not be considered for reentry into the Money Follows the Person project.

Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

In order to be considered for re-enrollment, an assessment must be completed to determine if adequate community resources are available to meet the medical needs of the individual. This will include verification by the transition coordinator of ongoing access to medical care specific to the needs of the individual.

Individuals Who Are Residing in Private Intermediate Care Facility- Mental Retardation Facilities or State-operated Intermediate Care Facility- Mental Retardation Facilities (Developmental Centers)* and *Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

In order to be considered for re-enrollment, a detailed person-centered plan including a transition plan is required to be completed by a team of individuals consisting of developmental center staff, Local Management Entity staff, and community providers with specific processes to ensure community sustainability. (Person-centered planning tools such as Essential Lifestyle Planning or Making Action Plans may be used.) Factors to be considered in the transition plan will include:

- medical issues and resources to meet the identified needs
- behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- a clear and well documented crisis plan that addresses not only intervention techniques but prevention processes
- residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members and informal supports

Informed Consent and Guardianship

This section sent to Karen Murphy of Disablity Rights NC for review and comments – 4/7/08

All individuals who wish to participate in the Money Follows the Person Demonstration Grant project, or if appropriate, the individual's legal guardian, will be asked to sign a consent form (see **Attachment B**) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants and/or their family and/or guardian will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

Informed Consent

Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Informed consent for participation in the Money Follows the Person Demonstration Grant project may be provided by the adult participant, emancipated minors, the parents of minors or the legal representative or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent named in a health care power of attorney. In cases where there is a legal representative or surrogate decision maker, the transition coordinator will review appropriate legal documentation to ensure that the individual possesses the legal authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

Individuals Who Are Residing in Private Intermediate Care Facility- Mental Retardation Facilities or State-operated Intermediate Care Facility-Mental Retardation Facilities (Developmental Centers)

Informed consent must be provided by the participant, unless that participant has been adjudicated as unable to make major life decisions in which case informed consent must be provided by the court-appointed guardian or legal representative.

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

The only individuals who can provide consent to participate in the Money Follows the Person Demonstration Grant project is the child/adolescent's legal guardian. Legal guardians will be provided with information during the person-centered planning process about the transition process and the services that will be provided to the participant by the primary community provider in conjunction with the Local Management Entity.

Guardianship

Chapter 35A of the North Carolina General Statutes contains the state's laws dealing with guardianship. In North Carolina, each of the state's 100 counties has a clerk of superior court who determines the appropriateness of guardianship and appoints a guardian if needed. Guardians are considered surrogate decision makers for individuals who are no longer capable of making and communicating decisions about themselves and/or their assets. The guardian's duty is to advocate for and assist the ward in exercising his/her rights.

A guardian may be an individual, such as a family member or friend; a corporation chartered to serve as guardian; or a disinterested public agent guardian. A disinterested public agent guardian may be the director or assistant director of a local human services agency (local Department of

Social Services, Local Management Entity, local health department or county department on aging) or an adult officer or agent of a state human services agency.

North Carolina General Statute 35A does not specify the level of interaction between a ward and an individual or corporation serving as guardian. It also does not address how frequently a guardian must visit with a ward. Corporations and disinterested public agent guardians submit annual status reports with the clerk of court's office detailing what has been done for the ward during a specified time period. These reports include the level of interaction between the guardian and the ward.

In regard to the Money Follows the Person Demonstration Grant project, legal representatives or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent appointed by the individual within the project will be required and agree to have contact with the individual identified for transition within the last six months. Only a court appointed guardian may act as guardian or other legally appointed representative for the participant. Legal guardians other than family members will follow the agency (which agency is being referred to? This statement was directly from the 11/6/07 notes from Carol Donin – maybe she knows) protocol for ensuring ongoing guardian interaction.

Because children and adolescents are eligible to participate in Money Follows the Person, only the parent or court appointed guardian may act as the guardian for the participant. Legal guardians other than family members will follow their agency protocol for ensuring on-going guardian interaction.

Training and Information

Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Each individual identified for transition to the community will be provided with information regarding protection from abuse, neglect, and exploitation and the process for notifying the appropriate authorities if the participant is subject to abuse, neglect or exploitation. This information will be given by the transition coordinator to the individual as well as to other identified family members, legal guardians, etc. during the person-centered planning process.

Individuals Who Are Residing in Private Intermediate Care Facility- Mental Retardation Facilities or State-operated Intermediate Care Facility- Mental Retardation Facilities (Developmental Centers)* and *Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

Each individual identified for transition to the community and, where applicable, his/her guardian or legal representative, will be provided with the following information regarding protection from abuse, neglect, and exploitation in the community and how to notify the appropriate authorities if the participant is subjected to abuse, neglect or exploitation. The information will be reviewed with the individual and his/her guardian/legal representative by the individual's planning team during the person-centered planning process.

Processes for ensuring protection from abuse, neglect, and exploitation include the following. Transition coordinators in collaboration with the Local Management Entity will be responsible for training the individual and legal guardians in this system of responding and reporting of critical incidents and other processes.

- The North Carolina Administrative Code requires all Local Management Entities and provider agencies to participate in a Department of Mental Health/Developmental Disabilities/Substance Abuse Services' coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and consumer behavior issues.
- Service providers are required to respond to all incidents by:
    - ensuring the safety of consumers and others,
    - documenting the incident and steps taken to remedy the situation, and
    - analyzing incident trends as part of the agency's quality improvement process.
- Incidents are divided into three levels of severity, which determines the intensity and breadth of the response:
    - level I: includes incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed.
    - level II: includes incidents with immediate or potentially serious adverse consequences to the consumer or others, including such events as injuries, abuse allegations, and use of restrictive interventions
    - level III: includes incidents with the most severe and permanent consequences-death or permanent impairment. In addition to the steps taken for all levels, providers must convene a team within 24 hours to address immediate needs regarding their safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and the Local Management Entity of steps taken.
- Provider agencies handle level I incidents internally and report aggregate numbers of level I incidents, identified trends, and activities being undertaken to address identified problems to the Local Management Entity quarterly.
- Provider agencies report level II incidents to the Local Management Entity within 72 hours. The Local Management Entity reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the reoccurrence of the incident in the future, and to make the required reports to other authorities.
- When there is reason to believe that an adult or child has been abused, neglected or exploited and in need of protective services, the incident is also reported to the local Department of Social Services and to the State Health Care Personnel Registry for investigation. Criminal acts are also reported to legal authorities for investigation.
- Provider agencies report level III incidents to both the Local Management Entity and the Department of Mental Health/Developmental Disabilities/Substance Abuse Services within 72 hours (or immediately if a death occurred within 7 days of seclusion or restraint of the individual).
- Local Management Entities report information on level II and III incidents to the Department of Mental Health/Developmental Disabilities/Substance Abuse Services quarterly, including aggregate numbers of types of incident, local trends identified in

the Local Management Entity's analysis and actions they have taken to prevent future incidents.

- The Department of Mental Health/Developmental Disabilities/Substance Abuse Services assures that individuals receive support to exercise their right and voice complaints. The Local Management Entity is the local hub for receiving complaints about service provision.
- In addition, per administrative rule, each area board for Department of Mental Health/Developmental Disabilities/Substance Abuse Services or Local Management Entity services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well.
- North Carolina General Statute 122C-64 states that the Client Rights Committee is responsible for protection of client rights and includes provisions regarding confidentiality, right to treatment and consent to treatment, use of corporal punishment, use of physical restraints or seclusion, and protection from abuse and exploitation.
- The Local Management Entity Client Rights Committee reviews incidents and consumer complaints, including alleged violations of the rights of individuals or groups, cases of alleged abuse, neglect or exploitation, concerns regarding the use of restrictive procedures, and failure to provide needed services that are available. The Committee reviews incidents occurring within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action.
- The Committee makes recommendations to the Local Management Entity board and may make report to local Department of Social Services and other applicable licensing agencies such as the Division of Health Services Regulation and the Division of Public Health.
- The Community Services Customer Rights team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainants and consumer information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts.
- Locally mortality reviews are conducted by the Quality Improvement Committee of the Local Management Entity.
- The Performance Contract with Local Management Entities requires that Local Management Entities produce reports and use for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends. Trends related to consumers include incidents, and client rights. Local Management Entities must report quarterly all incidents and deaths as well as complaints as part of the Performance Contract with Department of Mental Health/Developmental Disabilities/Substance Abuse Services.

Responsible Entities

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

The transition coordinators in collaboration with the local Department of Social Services adult protective service worker will be responsible for providing the individual and legal guardians with local information regarding who to contact and how to report suspected abuse, neglect, or exploitation and the process for reporting critical incidents.

Individuals Who Are Residing in Private Intermediate Care Facility- Mental Retardation Facilities or State-operated Intermediate Care Facility- Mental Retardation Facilities

(Developmental Centers)* and *Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

Transition coordinators in collaboration with the Local Management Entity will be responsible for providing the individual and legal guardians with local information regarding who to make protective services reports and the process for reporting critical incidents.

Outreach, Marketing, and Education

To support the successful implementation of the Money Follows the Person Demonstration Grant project, generic outreach and marketing materials will be developed to be used across a wide range of audiences and locations. A general information sheet template (**Attachment C**) will be available to all audiences. This template may be edited for use by state staff with specific audiences. Additionally, a flow chart template will be developed to explain the transition process. This template may also be edited to suit various audiences.

Participants

Participants in the Money Follows the Person Demonstration Grant project are those who have expressed an interest in transitioning and who wish to live and receive supports and services in the community of their choosing. There are several stages of information dissemination with regards to participants. These stages include pre-transition, post-transition and ongoing. During the pre-transition stage, potential participants will be notified about the opportunity into transition to the community. During the ongoing stages and post-transition (the three months after the transition), participants will be notified of additional services and supports in the community. Individuals and guardians will be kept informed of services available through Money Follows the Person demonstration grant throughout the project.

Providers

Providers in the Money Follows the Person Demonstration Grant project are those public, private, and community organizations that will provide services and supports to the participants so that they are able to successfully transition to and remain in the community. There are a wide variety of providers with multiple interests. Many providers have already been notified of the Money Follows the Person Demonstration Grant project. A "provider workgroup" has been formed and members of this group have been involved in reviewing the protocol and will continue to be involved through the life of the project. A mass mailing will also be designed for providers to ensure that a wide variety of providers is aware the Money Follows the Person Demonstration Grant project and the opportunities for involvement. Examples of service providers across the State are:

- Community providers
- Professional caregivers
- Nursing home administrators
- Health care workers
- Community Mental Health Centers
- Centers for Independent Living
- Aging and Disability Resource Connections

State Staff

State staff refers to the employees of the North Carolina Department of Health and Human Services (Department of Health and Human Services) who will be involved in the Money Follows the Person Demonstration Grant project. There are a wide variety of staff and Department of Health and Human Services divisions that are touched by this initiative. Examples of State agency/staff are:

- Department of Health and Human Services
- Division of Medical Assistance

- Division of Aging and Adult Services
- Division of Vocational Rehabilitation
- Office of Long Term Services and Supports
- Division of Vocational and Rehabilitation Services
- Department of Health and Human Services - Housing
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Other
Advocacy groups also serve as important audiences for Money Follows the Person Demonstration Grant project information. Division of Medical Assistance will design a mass mailing (using postcards) for various advocacy groups. The postcards used in the mass mailing will provide basic information about the Money Follows the Person Demonstration Grant project. Examples of advocacy groups across the State are:

- North Carolina Council on Developmental Disabilities
- Centers for Independent Living
- disAbility Rights and Resources
- Carolina Legal Association
- Coalition on Aging
- Friends of Residents
- Health Care Faculties Association
- Home Care Association
- Long Term Care Regional Ombudsman
- Mental Health Consumers Association
- National Alliance on Mental Illness
- Real Advocates Now Emerging
- Association of Self Advocates

Types of Media to be Used

Participants
Participants may receive information on Money Follows the Person demonstration grant services via brochures, broadcast messages (television or radio), in-person-visits to nursing facilities/institutions Medicaid card inserts, and through the Division of Medical Assistance's website at http://www.ncdhhs.gov/dma/MoneyFollows/MoneyFollowsPerson.html. Information will also be available on tape or CDs, videos and other forms, and media press releases,

Providers
Providers may receive information using the following media: Division of Medical Assistance bulletins (e-postings), Money Follows the Person Demonstration Grant project information sheet, Division of Medical Assistance's website, remittance advice banners, verbal recordings for providers to hear while "on hold" (on the phone) with Division of Medical Assistance, mass mailings (post cards) to provider associations and via inserts in conference "goodie bags".

State Staff
State staff may receive information via Division of Medical Assistance's website, fact sheets and through trainings.

Specific Areas to be Targeted

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Facilities throughout the state will be targeted through Nursing Facility Transition coordinators with the Centers for Independent Living and the North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program.

Individuals Who Are Residing in Private Intermediate Care Facility- Mental Retardation Facilities or State-operated Intermediate Care Facility- Mental Retardation Facilities (Developmental Centers)

Private Intermediate Care Facility-MR facilities and state-operated facilities (developmental centers) throughout the State will be targeted.

Individuals and their Legal Representatives Who Are Residing in a State-operated Psychiatric Hospital

- Cherry Hospital
- Broughton Hospital
- Dorothea Dix/John Umstead/Central Regional hospitals

Information Dissemination

The following resources will be used for information dissemination:

- Aging and Disability Resource Connections
- Various non-profit health care organizations, including:
  - National Multiple Sclerosis Society
  - ARC of North Carolina
  - Easter Seals/UCP of North Carolina
  - NAMI
  - Mental Health Association
  - Provider associations
- Local management entities (including Community and Family Advisory Committees)
- North Carolina Family Resource Line
- Centers for Independent Living
- Rehabilitation centers
- Nursing facilities
- North Carolina Division of Vocational Rehabilitation Independent Living program offices
- Senior Health Insurance Information Program/North Carolina Senior Medicare Patrol
- Long Term Care Ombudsmen offices
- North Carolina Council on Developmental Disabilities
- Providers of Programs for All-inclusive Care for the Elderly (PACE)
- Lead agencies for the CAP/DA
- disAbility Rights North Carolina (formally known as Carolina Legal Assistance
- Local libraries
- Community spaces (example: Parks and Recreation centers)

Staff Training

Annual training for Money Follows the Person services will be provided for stakeholders. This would include those who assist in transitioning individuals and others from the agencies

providing transition services. This training will be video taped. Each person who participated in the training will also have a six-month "refresher" session/video update.

Other options for trainings include conference calls and web based trainings.

Continuing Education Units should be offered to nursing facility staff, referring agencies and others. This was demonstrated to be a successful technique during North Carolina's Nursing Home Transition grant.

Bilingual Materials/Interpretation Services and Services for Individuals with Special Needs
Materials will be available in English and Spanish, and, upon request, in Braille and large print. Electronic materials will be accessible to those who use screen readers.

Informing Eligible Individuals of Cost Sharing Responsibilities
All materials intended for use by participants, their family, friends and guardians will include language that indicates the responsibility of the individual to participate in cost-sharing, if applicable.

Stakeholder Involvement

September 17, 2007, a Money Follows the Person Project Kick-off meeting was held to inform stakeholders and State staff about the project. This meeting gave an overview of the project; described the funders' (CMS) role and provided information on how the Operation Protocol would be developed. Dates for Town Hall meetings were announced and participants were encouraged to attend one close to them as a means of providing input into the development of the Operational Protocol and service delivery.

Stakeholder Chart

Stakeholder involvement is acquired through various committees and workgroups. The Money Follows the Person Demonstration grant is overseen and administered by Department of Health and Human Services. Leadership from Department of Health and Human Services is represented on the **Executive Committee**. This committee is to set policy and resolve issues. The **Stakeholders Advisory Group** provides input regarding the development and implementation of Money Follows the Person Demonstration grant. This group provides input toward structuring benefits and service deliveries that address the needs of consumers, providers, advocates, and other stakeholders. The **State Workgroup** developed the Operational Protocol, implements the benefit package, and responds to the administrative requirement for the project. The **Demonstration Workgroups** are comprised of providers, consumers, advocates, and staff to provide specifics on system issues facing long term care services delivery and needed changes. See **Attachment D**.

Consumer Involvement

Consumers, advocates and others were invited to participate in six demonstration workgroups as a prerequisite to developing the operational protocol for the Money Follows the Person Demonstration Grant project. As the protocol was developed, this group was consulted and was provided with an opportunity to review and comment on the draft.

Town Hall meetings were held across the state to solicit input into the development, implement, and evaluation of Money Follows the Person. A letter was sent to consumers of long term services services, consumer advocates, Local Management Entities, County Department of Social Service Directors and long term care services providers to share with stakeholders inviting them to the meetings. From this meeting, information was compiled and integrated into the Operational Protocol and will be considered as services are implemented.

Additionally, consumers, families of consumers, providers, and advocates were asked to participate in an application/nomination process for participation in ongoing Stakeholder Advisory Group meetings. Members are defined as consumers and/or family members of consumers who receive publicly financed long term care services; agencies or providers; or representatives of people who are aging with care needs, have an intellectual or other developmental disability, have a physical disability, have a mental illness, or have a dual (or multiple) diagnosis. This group is comprised of 60% consumers and/or their families and 40% providers. This group will meet four to six times per year.

Providers Involvement

Institutional providers, consumers, advocates, and State staff were invited to participate in provider issues workgroups. These providers will also be asked to participate in ongoing Stakeholder Advisory Group meetings.

Roles and Responsibilities

The stakeholders will be responsible for providing input to the six workgroup focus areas as well as to provider issues. An orientation to Money Follows the Person project components and deliverables was provided at each initial meeting of workgroups and stakeholders. During the demonstration project implementation phase, stakeholders at all levels will be responsible for providing input to six workgroup focus areas. The six workgroup focus areas are:

- Participant Recruitment/Enrollment/Informed Consent/Guardianship
- Housing
- Outreach, Marketing, and Education
- Provider Issues
- Benefits/Services/Consumer Supports/Self-Direction
- Quality Assurance/Continuity of Care

Operational Activities

Each year, Division of Medical Assistance will coordinate four state forums to be held in conjunction with the Quarterly Stakeholder Advisory meetings; these meetings will rotate to locations around the state. These forums will be open to the pubic and efforts will be made to invite a wide range of potential participants, their families, friends and guardians, providers, state staff and other important community stakeholders.

Benefits and Services

Service Delivery Systems

In North Carolina, the Money Follows the Person Demonstration Grant project will be used to transition individuals into existing 1915(c) home and community based waiver programs. A separate demonstration 1915(c) waiver will not be created for the ongoing services provided through the Money Follows the Person Demonstration Grant project. After 365 days of demonstration services, individuals will continue in the same 1915(c) waiver program as long as they meet the eligibility requirements of the program.

North Carolina currently operates two 1915(c) waivers that target individuals who are aging and/or have disabilities as an alternative to residing in a nursing facility: CAP/DA and CAP/Choice. North Carolina also operates a 1915(c) waiver that targets individuals with intellectual or developmental disabilities as an alternative to residing in a private Intermediate Care Facility-Mental Retardation or a state-operated Intermediate Care Facility-Mental Retardation (developmental center): CAP/MR-DD.

Division of Medical Assistance also operates a 1915(b) and (c) waiver, Piedmont Behavioral Health Plan, which provides behavioral health and substance abuse services as the Piedmont Cardinal Health Plan, as well as services to individuals who have intellectual/developmental disabilities as the Piedmont Innovations Program. This waiver is provided to recipients in Cabarrus, Davidson, Rowan, Stanly, and Union counties.

The chart below describes the services currently covered under existing CAPs. Additionally, the last column provides information regarding services that will be covered under the demonstration program. The target population consists of North Carolina individuals who are currently residing in institutional care for a period of 6 months or more from one of the following categories:

- Developmental disabilities
- Acquired brain disorders
- Elderly and chronically ill
- Families with children with severe developmental disabilities requiring in-home support
- Behavioral health
- Physically disabilities

	Currently Covered Services			**Recommendation to Provide as Waiver Service**
	PIEDOMNT INNOVATIONS; CAP/MR-DD	**CAP/DA**	**CAP/Choice**	
Adult Day Care	YES	NO	NO	YES
Augmentative Communications	YES $10,000/year limit	NO	NO	YES
Crisis Services	YES Periods of up to 14 days; 2016 hours/year limit	NO	NO	YES
Day Supports	YES	NO	NO	YES
Home and Community	YES	NO	NO	YES

Supports				
Home Modifications	YES $15,000 limit over waiver duration (3-year period)	YES $1,000 limit over 1-year period	YES	YES
Individual/Caregiver Orientation/Training/Education	YES	NO	NO	YES
Personal Care Services/In-home Aide Services (Level I and Level II)	YES (Personal Care Services)	YES (In-home Aide Services)	YES	YES Expand to include additional levels (chore aide and extensive home management aide) to coincide with level of service provided through Aging Block Grants
Personal Emergency Response Services/Telephone Alert	YES	YES (Telephone Alert)	YES	YES
Residential Supports (Group Homes)	YES	NO	NO	YES
Respite Care	YES	YES	YES	YES
Enhanced Respite Care	YES	NO	NO	YES
Institutional Respite Care	YES	YES	YES	YES
Non-institutional Respite Care	YES	NO	NO	YES
Specialized Consultative Services (psych counseling, therapy counseling, nutrition counseling, etc.)	YES	NO	NO	YES
Vehicle Modifications	YES $3,000 per year for a 3-year period	NO	NO	YES
Specialized Equipment (Home Mobility Aids)	YES (Specialized Equipment) $1500/year limit	YES (Home Mobility Aids) $1500/year limit	YES	YES
Employment Support	YES	NO	NO	YES
Non-medical Transportation	YES	NO	NO	YES
Waiver Supplies	NO	YES	YES	YES
Hospice Care	NO	NO for Medicaid only YES for dually eligible	NO for Medicaid only YES for dually eligible	YES
Consumer-directed Care Advisor	NO	NO	YES	YES
Case Management	YES	YES	NO	NO
Financial Management	NO	NO	YES	YES
Consumer-directed Goods and Services (equipment and services not covered through State Plan that are needed to increase ability to complete activities of daily living and instrumental activities of daily living and to decrease dependence on aide services)	NO	NO	YES $600/year limit	YES

Service Package

CAP/DA

The Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults (age 18 and older) who qualify for nursing facility care to remain in their private residences. The current CAP/DA waiver provides services and supports to individuals who meet the nursing facility level of care who can be safely and effectively served in the community. Services include:

- Adult day health care
- In-home aide services, level II and level III (includes personal care)
- Waiver Supplies: incontinence supplies, oral nutritional supplements, medication dispensing boxes
- Case Management
- Home Mobility Aids – adaptations to home environment (such as wheelchair ramps, safety rails, grab bars, non-skid surfaces, etc.)
- Preparation and delivery of meals
- Respite care, in-home
- Respite care, institutional
- Telephone alert (phone line system)
- Attendant care services
- Private duty/independent nursing service(s) – licensed

CAP/Choice

The Community Alternatives Program Choice (CAP/Choice) is a program of consumer-directed care for aging and disabled adults (age 18 and older) in four counties: Cabarrus, Duplin, Surry, and Forsyth, who qualify for nursing facility care to remain in their private residences. CAP/Choice provides the individuals with increased control over their services and supports and provides the ability to more fully direct their care. CAP/Choice provides the individuals with more flexibility in tailoring their plans of care to their home care requirements. In addition to the services provided through the CAP/DA waiver, CAP/Choice participants have access to:

- Consumer-directed care advisor
- Consumer-directed financial management
- Consumer-directed goods and services (equipment and services not covered through the State Plan that are needed to increase the individual's ability to complete activities of daily living and to decrease dependence on aide services)

Note: Because CAP/Choice provides consumer-directed care advisors, case management is not a direct service component of the waiver.

CAP/MR-DD

The Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP/MR-DD) provides community services to individuals of any age who qualify for care in an intermediate care facility and individuals who have intellectual disabilities (mental retardation) (Intermediate Care Facility-Mental Retardation). Services include:

- Targeted case management
- Adult day health care

- Personal care services
- Enhanced personal care services
- Augmentative communications (purchase and repairs/service)
- Crisis services
- Day supports (group or individual)
- Home and community supports (group or individual)
- Home modifications
- In-home aide services, level II and level III
- Individual caregiver training and education
- Personal emergency response service
- Respite care, enhanced
- Respite care, institutional
- Respite care, non-institutional nursing-based (registered nurse, licensed practical nurse)
- Residential supports (levels 1 through 4)
- Specialized consultative services
- Specialized equipment and supplies
- Supported employment (group or individual)
- Transportation, non-medical
- Vehicle adaptations

Piedmont Cardinal Health Plan/Piedmont Innovations Waiver

Piedmont Cardinal Health Plan is a prepaid managed care plan administered by Piedmont Behavioral Healthcare, a public mental health, developmental disabilities, and substance abuse services organization. Piedmont Cardinal Health Plan includes all Medicaid-covered mental health and substance abuse services as well as the new Piedmont Innovations waiver program, which replaces CAP/MR-DD in the five-county area – Cabarrus, Davidson, Rowan, Stanly, and Union. PCHP also includes intermediate care facilities for the individuals who have intellectual disabilities and psychiatric inpatient hospitalizations.

PACE (Program of All-Inclusive Care for the Elderly)

The Program of All-Inclusive Care for the Elderly is a managed care program that enables elderly individuals who are certified to need nursing facility care to live as independently as possible. The Program of All-Inclusive Care for the Elderly provider receives monthly Medicare and/or Medicaid capitation payments for each eligible enrollee. The Program of All-Inclusive Care for the Elderly provider assumes full financial risk for participants' care without limits on amount, duration, or scope of services.

Effective February 1, 2008, to enroll in this program, an individual must be Medicaid eligible and;

- **Be 55 years of age or older**
- **Certified by the State to require nursing facility level of care**
- **Able to live safely in the community at the time of enrollment, and**
- **Reside in the service area of the Program of All-Inclusive Care for the Elderly organization. Currently, Program of All-Inclusive Care for the Elderly is only available in New Hanover and Brunswick counties through the Elderhaus, Inc. Program of All-Inclusive Care for the Elderly Program (began operating February**

1, 2008). Additionally, Program of All-Inclusive Care for the Elderly sites are being developed in Fayetteville, North Carolina (projected start date of 2009) and Burlington, North Carolina (projected start of September 1, 2008).

Services provided by the Program of All-Inclusive Care for the Elderly include, but are not limited to:

- **All Medicaid-covered services, as specified in the State's approved Medicaid plan**
- **Multidisciplinary assessment and treatment planning**
- **Social work services**
- **Skilled nursing care**
- **Primary care physician services**
- **Medical specialty services**
- **Specialized therapies**
- **Recreational therapy**
- **Personal care services**
- **Nutrition counseling**
- **Meals**
- **Medical Supplies**
- **Home Mobility Aides**
- **Transportation**
- **Prescriptions**
- **Laboratory tests, X-rays, and other diagnostic procedures**
- **Prosthetics, orthotics, durable medical equipment and corrective vision devices**

Transition Services

One-time set-up transition expenses for individuals who are transitioning from a nursing facility, a state-operated developmental center or private Intermediate Care Facility-Mental Retardation group home, or a state-operated psychiatric hospital to a community setting or another living arrangement where the person is directly responsible for his/her own living expenses include the following:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, bed/bath linens;
- Set-up fees or deposits for utility or service access including telephone, electricity, heating and water; and
- Service necessary for the individual's health and safety such as pest eradication and one-time clearing prior to occupancy.

Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. Transition services do not include monthly rental or mortgage expenses; regular utility charges; and/or household appliance or diversion/recreational items such as televisions, VCRs, and DVDs. These services will be provided only once and may not be accessed for any subsequent moves within the community.

State Plan Services
In addition to the waiver program services, all Money Follows the Person participants will be eligible for Medicaid State Plan Services. This contradicts Quality section that states State Plan will not be utilized

Supplemental Demonstration Services
Under the demonstration grant, the supplemental services will be provided and reimbursed with demonstration funds. These services are not long term in nature, but may be essential for successful transition to the community.

- Assistive technology (ex., computer)
- Durable medical equipment
- Nutrition services
- Substance Abuse
- Housing
  - Furnishings
  - Security deposits
  - Utility set-up fees
  - Adaptive equipment/assistive technology to facilitate sustained community living
  - Home modifications and retrofitting
- Service animals
- Transportation – one time solutions
- Family support services (such as training the crucial informal support network on services available)
- Private duty nursing
- Health and safety assurance
- Independent Living Skills
- Vehicle Modifications
- Tele-health monitoring equipment
- Products for the maintenance of health and hygiene

Transition at termination
The 1915(c) waivers and the State Plan will provide services at the termination of the Money Follows the Person project. Program participants will also be assisted to access other community-based services for which they may qualify.

Consumer Supports

Educational Materials
Division of Medical Assistance will develop informational brochures that outline the services provided through Money Follows the Person. Current consumer information will be updated to include information about the Money Follows the Person Demonstration Grant project.

Back-up Systems
CARE-LINE. The North Carolina Department of Health and Human Services toll-free information and referral telephone service, CARE-LINE [1-800-662-7030; local calls: 855-4400 or 919-733-4851 (TTY)], is available to provide information and referrals regarding human services in government and non-profit agencies. A database of over 10,000 agencies across North Carolina is available to staff who are assisting callers. The CARE-LINE is available 24 hours, 7 days a week, effective March 27, 2008. Consumers, their families, and other customers have a service to call which provides information and referrals on a wide array of human services any time of the day or night.

careLink. North Carolina maintains a comprehensive health and human services web site called careLINK (http://www.nccarelink.org). It is a collaborative effort of the North Carolina Department of Health and Human Services and many other government and non-profit information and referral stakeholders across North Carolina. This web site provides up-to-date information about programs and services across North Carolina for families, seniors, youths and everyone in-between.

Individuals may also access 911, the statewide suicide hotline at 1-800-273-8255, and/or visit the emergency room at a local hospital.

Personal Emergency Response System (PERS). Personal Emergency Response System is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals from the company ADT Security Services. Personal Emergency Response System services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Consumer Complaints
The Department of Health and Human Services Ombudsman Program was created to address inquiries and complaints that consumers have regarding services that Department of Health and Human Services oversees or administers. Through this service, Office of Citizen Services staff serves as the central point of contact for the Department of Health and Human Services Secretary's Office, Governor's Office, other elected and appointed officials, department personnel, all government agencies, non-profit and private agencies, advocates and residents of the state.

Constituents who contact their governmental representatives or any human service professional with complaints concerning Department of Health and Human Services or who are in need of human service programs are referred to the Department of Health and Human Services Ombudsman Program. When a complaint is received, Office of Citizen Services staff serves as a liaison between the resident and the Department of Health and Human Services program specialist. Office of Citizen Services staff ensures that complaints are thoroughly examined and investigated. Staff determines the most appropriate parties to contact and work with to resolve the situation. Feedback is provided to elected officials regarding their constituents' concerns. Ensuring that consumers have the proper channel for addressing their concerns is the key to this program. If a person's complaint is valid, steps are taken to rectify the situation. If the complaint is not valid, time is spent with the resident to educate him/her on the process and help the person understand why the situation was handled in a certain manner. In addition, staff relies on an extensive statewide database to give additional referrals that may be of assistance.

The Regional Long Term Care Ombudsmen program can also be accessed through the CARE-LINE and is available Monday through Friday, except state holidays, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

Self-Direction

Self direction is an *option* afforded to individuals under CAP/Choice waiver program. CAP/Choice is a program of participant-directed care for elderly and disabled individuals, and/or their family/guardian, who wish to remain at home and have increased control over their services and supports. CAP/Choice reflects North Carolina's health reform policy objectives of promoting consumer choice and decision-making, reducing health-care costs, and identifying key stakeholders, especially consumers in its approach to reform the delivery of services.

North Carolina's Division of Medical Assistance is committed to expanding the CAP/Choice program statewide. The services under CAP/Choice are currently offered in four North Carolina counties: Cabarrus, Duplin, Forsyth, and Surry. The waiver was approved March 31, 2008 with a retroactive date for services of January 1, 2008. A systematic roll-out to all of North Carolina's remaining counties will begin January 1, 2009. CAP/Choice services will become an option under the traditional CAP/DA waiver program, which is already implemented statewide. Training specific to CAP/Choice will be provided to the CAP/DA lead agencies not already providing CAP/Choice services. It is proposed under the framework of the amended CAP-MR/DD waiver, that self-direction be an option for individuals in Tier 1 and Tier 2.

North Carolina's Money Follows the Person Demonstration Grant project includes the same services as the CAP/Choice waiver with regard to compliance with the Freedom of Choice requirement. Participants and/or their family/guardian may choose any willing and qualified provider; receive information about providers; select whom to interview; and meet, interview and select the provider of their choice.

Under CAP/Choice, participants will be able to:
• Choose (hire) the Personal Assistant who will provide their care support
• Train, supervise and evaluate the worker
• Negotiate the rate of pay and other benefits
• Terminate the worker should this become necessary
• Select individual providers and direct reimbursement for specified waiver services
• Engage in a cooperative working arrangement with a financial manager (FM) who will pay the participant's worker, handle federal/state taxes and other payroll/benefit functions related to the employment of the worker, and reimburse service providers under the direction of the participant.

Self-Direction Support Provisions: Self-Directed Services is an option afforded the individual (or in the case of children, their parents or other legally responsible relatives) and others that the individual asks to assist him/her to direct some or all of the services and supports in their person-centered plan Self-directed means that the individual or the family (in the case of minors) hires and directs the provider of services and directly authorizes the financial management services provider to make payment on the participant's behalf for a goods or service included in the person-centered plan.

Care advisors will inform individuals and/or families/guardians of the option to direct services and supports during the assessment and person-centered planning process. Each plan of car will include a risk assessment and identify appropriate risk management strategies. The individual who desires to direct his/her services will be assessed to determine if the individual is able to

independently direct services. If the individual has a court appointed guardian, is a minor, or is assessed as needing assistance to direct services, a representative will be required for the individual to participate in Self-Directed Supports Option. The representative may be a family member, friend, legal guardian, other legally appointed representative, or income payee. A person who provides services to the individual may not be the representative. This includes any employee of a licensed facility where the individual lives or any member of an Alternative Family Living or foster home where the individual lives. The representative must:

- Demonstrate knowledge and understanding of the individual's needs and preferences
- Agree to a predetermined level of contact with the individual
- Be willing and able to comply with program requirements
- Be at least 18 years of age
- Be approved by the individual and/or his/her legal representative to act in this capacity.

Care advisors will be responsible for identifying the need for a representative for the individual and assuring that the representative meets established criteria.
Individuals who are considering the Self-Directed Supports Option will be provided educational opportunities and materials. They will have further educational opportunities through individual training and education services. The individual, in conjunction with the planning team, will assess the need for Supports Brokerage and the specific activities to be performed for CAP/MR-DD participants. Care advisors will also be responsible for ensuring that the person-centered plan identifies how emergency back-up services will be furnished for workers employed by the individual. As an added safeguard, provision may be made via on-call service agreements with licensed home health agencies to provide staff in the event that emergency back-up strategies, identified in the person-centered plan, cannot be implemented and there is the potential that the person's health and welfare would be jeopardized. The individual's care advisor will authorize the provision of these on-call emergency back-up services.

See Attachment ? for further details regarding Self-Direction as an option for individuals under CAP/Choice services.

Quality Management

Quality Assurance for Integrating Services into New or Existing 1915(c) Waivers

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

North Carolina intends to integrate the Money Follows the Person Demonstration Grant services into an existing 1915(c) waiver for individuals who require the level of care provided by a nursing facility transitioning to the community. The same level of quality that applies to the CAP/DA waiver will apply to those individuals during the transition and during the demonstration.

Individuals Who Are Residing in Private Intermediate Care Facility-Mental Retardation Facilities or State-operated Intermediate Care Facility- Mental Retardation Facilities (Developmental Centers)

North Carolina intends to integrate the Money Follows the Person Demonstration Grant services into an existing 1915(c) waiver for individuals with developmental disabilities transitioning from a state-operated developmental center or private Intermediate Care Facility-MR facilities. The same level of quality that applies to the CAP/MR-DD waiver will apply to those individuals during the transition and during the demonstration.

Quality Assurance for State Plan Services

North Carolina will not utilize 1915(b), State Plan Amendment or 1115 waivers. Only 1915(c) waivers will be utilized.

Waiver Assurances

CAP/DA and CAP/Choice

? Larry Nason states this is under revision and will provide by mid-April (3/19/08)

Attachment ? provides information from Appendix H of the CAP/Choice Waiver Application Amendment.

CAP/MR-DD

North Carolina's Quality Management plan for the current 1915(c) Home and Community Based Waiver for individuals with developmental disabilities can be found in Attachment section ("Quality Management Plan – 1915(c) Waiver"). This plan reflects processes for assuring that the Money Follows the Person Demonstration Grant project will reflect the same level of quality assurance and improvement activities required under Appendix H of the Home and Community Based Waiver application for those individuals transitioned to the community into a home and community based services waiver during the demonstration.

Level of Care Determinations

CAP/DA and CAP/Choice

Local lead agencies are responsible for coordinating with case managers in the assessment of the individual's strengths and needs in six basic areas of functioning to determine individuals who are potentially eligible for waiver services, assuming funding availability and that the individual meets the nursing facility level of care.

A continued need review is completed annually for all participants. The statewide utilization review vendor reviews continued need reviews including the long term care level form (FL-2) reflecting the nursing facility level of care.

The instruments and process for determining level of care are the same as those described in the approved waiver. Nursing facility level of care criteria is applied to determine eligibility for the waiver. Documentation of nursing facility level of care is provided using the long term care level form (FL-2).

CAP/MR-DD

Local Management Entity's are required through Performance Measures in the Local Management Entity Performance Contract to provide a system of screening, triage and referral to services in a prompt, user-friendly manner. This includes individuals who are potentially eligible for waiver services, assuming funding availability and that the individual meets the Intermediate Care Facility – Mental Retardation level of care. Individuals referred for waiver funding have their level of care assessed by a psychologist or physician. Clinical staff employed by Division of Mental Health – Developmental Disabilities/Substance Abuse Services makes the final determination of level of care.

A continued need review is completed annually for all participants by a Qualified Professional in the field of developmental disabilities. The Local Management Entity is responsible for signing the mental health services level form (MR-2) reflecting Intermediate Care Facility-Mental Retardation level of care at the annual continued need review. The statewide utilization review vendor conducts continued need reviews including the mental health services level form (MR-2) reflecting the Intermediate Care Facility-Mental Retardation level of care. (Ann Eller questioned: Does the LME or the UR vendor do the continued need review?)

Clinical staff employed by Division of Mental Health – Developmental Disabilities/Substance Abuse Services through the Murdoch Developmental Center maintains a spreadsheet to record timeliness of level of care reviews. Division of Medical Assistance staff audit a random sample of 15 records monthly, which includes a review of the level of care determination.

Program of All-Inclusive Care for the Elderly (PACE)

Prior to enrollment in Program of All-Inclusive Care for the Elderly, Medicaid must certify tat the applicant meets the state's nursing facility level of care criteria. Annually, the Program of All-Inclusive Care for the Elderly organization must submit the Long-Term Care Uniform Screening Tool each year to verify that the enrollee continues to meet nursing facility level of care requirements.

Plan of Care/Person-Centered Plan Development

CAP/DA and CAP/Choice

Case managers employed by individual provider agencies are responsible for developing each person-centered plan to address the services that are needed to maintain the individual's health, safety, functions, and independence.

Case managers revise the plan as needed. Division of Medical Assistance contracts with a statewide vendor to monitor plans to assure that:

- participants continue to meet the criteria for nursing facility level of care;
- re-evaluations are conducted annually;
- participants are provided with the option for institutional care; and
- services are delivered as approved.

CAP/MR-DD
Case managers employed by individual provider agencies through a contract with the Local Management Entity (Ann Eller: believes case management providers directly enroll through DMA; which is it?) develop an individual person-centered plan for each applicant/participant and 100% of these plans are submitted for review and approval through a statewide utilization review vendor.

Case managers revise Plans of Care as needed. Revised plans must be approved by the statewide utilization review vendor.

Case managers monitor Plans of Care to determine whether services are delivered as approved. Local Management Entities monitor service provision through review of paid claims data reflecting the amount and frequency of services billed for specific consumers on an as-needed-basis, as well as through post-payment reviews. The State audits a random sample of 15 records monthly through Division of Medical Assistance's Behavioral Health Unit, Quality Assurance Reviews, which includes a review of encounter data/paid claims. In addition, Department of Health and Human Services/Developmental Disabilities/Substance Abuse Services Program Accountability Team and Division of Medical Assistance's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services

Case managers monitor appropriateness of service delivery in light of any changes in the consumer's needs. Monthly face-to-face monitoring is required. Local Management Entities have responsibility through the Performance Contract with the Department of Mental Health/Developmental Disabilities/Substance Abuse Services to produce reports and use for planning and improvement. These include provider trends such as assessment of provider quality, results of audits and monitoring activities, technical assistance, and trainings. The reports analyze and summarize patterns and trends related to providers. All initial person-centered plans, revisions to the person-centered plans, and care of need reviews are reviewed and approved by a statewide utilization review vendor. The State audits a random sample of records monthly through Division of Medical Assistance's Behavioral Health Unit/Quality Assurance Reviews, which includes a review of encounter data/paid claims. Department of Mental Health/Developmental Disabilities/Substance Abuse Services Program Accountability Team and Division of Medical Assistance's Behavioral Health Unit conduct a Medicaid Compliance Audit that includes waiver services. (Ann Eller suggest deleting)

Identification of Qualified Home and Community Based Services Providers for those Participants Being Transitioned
CAP/DA and CAP/Choice
Participants are offered choices of waivers versus institutional care and between/among providers. Choice must be documented in the person-centered plan. The local lead agencies are responsible for verifying that providers within their catchment areas meet all the requirements to provide CAP/DA services. The Division of Medical Assistance Provider Enrollment Unit is responsible for enrolling all CAP/DA providers based on meeting endorsement criteria.

Program of All-Inclusive Care for the Elderly (PACE)
Following the required assessments (physical, functional, psychosocial, health and safety), the

Program of All-Inclusive Care for the Elderly program must develop a plan of care on a form approved by Division of Medical Assistance for approval. The plan of care must be updated and submitted to Division of Medical Assistance for approval at least annually.

CAP/MR-DD

Participants are offered choices of waivers versus institutional care and between/among providers. Choice must be documented in the person-centered plan.

The Local Management Entity is responsible for verifying that providers within its catchment area meet all the requirements to provide CAP/MR-DD services through the endorsement process. The Local Management Entity is responsible for performing provider endorsement activities in accordance with the policies, processes, and timeframes outlined in the Department of Health and Human Services Provider Endorsement policy. The Division of Health Service Regulation is responsible for licensure of all healthcare facilities in which CAP/MR-DD waiver recipients may reside. The Division of Medical Assistance Provider Enrollment Unit is responsible for enrolling all CAP/MR-DD providers based on meeting endorsement criteria.

Local Management Entities maintain responsibility through the Performance Contract with the Department of Mental Health/Developmental Disabilities/Substance Abuse Services to provide ongoing monitoring of providers within their catchment areas. In addition, if through the monitoring process it is determined that the provider no longer meets the requirements of endorsement to provide a specific CAP/MR-DD service, the Local Management Entity may withdraw endorsement resulting in withdrawal of to provide and bill for the specific service. The State provides monitoring of providers as well through annual Department of Mental Health/Developmental Disabilities/Substance Abuse Services and Division of Medical Assistance Medicaid Compliance Audits. Department of Mental Health/Developmental Disabilities/Substance Abuse Services has in place a protocol for summary suspension and revocation of authorization to receive public funding for providing MH/DD/SAS services.

Enrolled providers are required to ensure that all direct care staff receive required training as outlined in Appendix B-2 of the CAP/MR-DD waiver, Provider Qualifications. Local Management Entities maintain responsibility through the Performance Contract with the Department of Mental Health/Developmental Disabilities/Substance Abuse Services to provide ongoing monitoring of providers within their catchment area. Local Management Entities have responsibility through the Performance Contract with the Department of Mental Health/Developmental Disabilities/Substance Abuse Services to produce reports and use for planning and improvement. These include provider trends such as assessment of provider quality, results of audits and monitoring activities, technical assistance, and trainings. The reports analyze and summarize patterns and trends related to providers. The state provides monitoring of providers as well through annual Department of Mental Health/Developmental Disabilities/Substance Abuse Services and Division of Medical Assistance Medicaid Compliance Audits.

Health and Welfare

CAP/DA and CAP/Choice

Case managers maintain responsibility for monitoring each waiver participant's changing needs, situation or condition. The case manager monitors the services to the participant through direct observation, including a monthly face-to-face visit, participant report, and review of provider

documentation. Case managers are responsible for reporting any need for protective services due to suspected abuse, neglect, or exploitation to the county Department of Social Services as well as the provider agency.

CAP/MR-DD

Case managers maintain responsibility for monitoring waiver participant's changing needs, situation or condition, including a monthly face-to-face visit. Case managers are responsible for reporting any need for protective services based on requirements in state legislation to the county Department of Social Services as well as the provider agency. The North Carolina Administrative Code requires all Local Management Entities and provider agencies to participate in a Department of Mental Health/Developmental Disabilities/Substance Abuse Services-coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and consumer behavior issues. In addition, per administrative rule, each area board for MH/DD/SAS services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well. Local mortality reviews are conducted by the Quality Improvement Committee of the Local Management Entity. The Community Services Customer Rights Team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainant and consumer information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts.

Program of All-Inclusive Care for the Elderly (PACE)

The PACE program must also conduct a comprehensive health and safety assessment to ensure that the applicant's health, safety, or welfare will not be jeopardized by living in the community. The assessment must include

a. An on-site evaluation of the applicant's residence
b. An evaluation of the applicant's social support system, including the willingness and capabilities of all informal caregivers
c. An evaluation of whether the applicant can be safely transported to the PACE center

Administrative Authority for the Waiver

CAP/DA and CAP/Choice

Division of Medical Assistance is responsible for monitoring program administration for the CAP/DA waiver. Division of Medical Assistance provides information and guidance to counties that have CAP/DA programs and conducts annual on-site visits to review program operations and the provision of technical assistance to facilitate management of the program.

CAP/MR-DD

Department of Mental Health/Developmental Disabilities/Substance Abuse Services and Division of Medical Assistance are responsible for monitoring program administration. Department of Mental Health/Developmental Disabilities/Substance Abuse Services is the lead agency for statewide operations of the CAP/MR-DD waiver and Division of Medical Assistance oversees the overall operation of the waiver according to federal and state guidelines. These divisions cooperate in the operation of the waiver under a Memorandum of Understanding that delineates each division's responsibilities.

Financial Accountability

CAP/DA and CAP/Choice

The Medicaid Program's fiscal agent Electronic Data Systems Corporation is responsible for ensuring that CAP/DA and CAP/Choice claims are paid correctly through a contract with Division of Medical Assistance. Electronic Data Systems Corporation has established edits and audits in the claims payment system to ensure payment is made in accordance with the approved methodology.

Division of Medical Assistance Program Integrity conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarifications.

Post-payment reviews by Division of Medical Assistance look at the complete audit trail: the approval of the person-centered plan, the case manager's authorization to the provider to render approved services, service provision, service documentation and the case manager's authorization for claims submission and actual claims data.

CAP/Choice participant files are monitored as submitted and/or changed by Division of Medical Assistance's Quality Assurance contractor, Carolinas Center for Medical Excellence. Quality assurance reviews determine that participants are classified correctly at either intermediate care or skilled nursing level of nursing facility care. Results of monthly monitoring are reviewed by Division of Medical Assistance CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/Choice is operated. The QA review process is not a negative process, but one that leads to the strengthening of program. Additionally, Carolinas Center for Medical Excellence looks at claims data for possible inappropriate payment of services and monthly budget monitoring.

Division of Medical Assistance's Program Integrity Section is tasked with multiple responsibilities. These include:

- coordinating fraud, abuse, and administrative over-payments.
- determining the accuracy of Medicaid eligibility determinations.
- collecting money and cost avoiding Medicaid payments.
- assisting in claim payment audits.
- conducts periodic reviews with providers who bill for payments.
- referring cases of possible fraud to the Attorney General's Medicaid Investigations unit.

The efforts of the Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered.

North Carolina fiscal agent, Electronic Data Systems Corporation monitors waiver providers for fiscal accountability through post payment audits of paid claims. EDS has established edits and audits in the claims payment system to ensure payment is made in accordance with the approved methodology.

CAP/MR-DD

The Medicaid Program's fiscal agent Electronic Data Systems Corporation is responsible for ensuring that CAP/MR-DD claims are paid correctly through a contract with Division of Medical Assistance. Electronic Data Systems Corporation has established edits and audits in the claims payment system to ensure payment is made in accordance with the approved methodology. The Resource/Regulatory Team of the Department of Mental Health/Developmental Disabilities/Substance Abuse Services also develops a monthly report that describes the services paid for waiver recipients, the number of units billed, the cost and the number of consumers receiving each service. This data provides the ability to view services paid per individual consumer, as well as per individual Local Management Entity or provider. This data may be used in the event that there is a concern or complaint received regarding a specific consumer or provider. The Department of Mental Health/Developmental Disabilities/Substance Abuse Services Accountability Team and Division of Medical Assistance's Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events per a sample of individual directly enrolled providers. This review includes monitoring of both Division of Medical Assistance/Waiver and Department of Mental Health/Developmental Disabilities/Substance Abuse Services requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocol. These reviews assure that documentation and other requirements were followed for services that providers billed to Medicaid and for which they were paid. Division of Medical Assistance Program Integrity conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarifications.

Housing

Assuring Sufficient Qualified Residences

The lack of affordable and accessible housing in North Carolina remains a significant barrier to meeting the needs of extremely low income households, the elderly, and persons with disabilities, in their communities. However, North Carolina has made significant, if limited, progress in this area over the past five years. In May of 2002, former Department of Health and Human Services Secretary established the position of Housing Coordinator within this office. The Department of Health and Human Services Housing Work Group (HWG), with representatives of all Department of Health and Human Services service divisions, was formed to implement the broad agenda for this new initiative: reducing fragmentation of housing efforts within the Department; increasing the housing capacity of the State and local agencies to maximize existing housing resources; and more effectively engaging the affordable housing industry to expand supportive housing opportunities for Department of Health and Human Services constituents.

As a result of this department level commitment, the North Carolina Housing Finance Agency has partnered with Department of Health and Human Services since 2002 to facilitate the inclusion of persons with disabilities within Low Income Housing Tax Credit (Housing Credit) properties. All Housing Credit properties funded in North Carolina since 2004 must develop a Targeting Plan that makes 10% of the units available to extremely low income persons with disabilities, including those who are homeless. To date, over 1,175 units of quality, affordable rental housing have been funded. The Key Program, an operating assistance program created by North Carolina Housing Finance Agency and Department of Health and Human Services, is also available to Housing Credit properties funded since 2004 to ensure targeted units are affordable to persons with incomes as low as Supplemental Security Income (SSI). Since 2006, 5% of units in all new Housing Credit properties must meet a higher than legally mandated level of accessibility, including curbless showers and full turn-around bathrooms.

In 2004, the Department's Housing Work Group prepared a successful grant application to CMS for a Real Choice Systems Change Grant: Integrating Long Term Supports with Affordable Housing. The grant, a partnership between the Department of Health and Human Services and the North Carolina Housing Finance Agency, was designed to bring technical assistance to local communities to expand the collective capacity of the human service system to implement the Housing Credit targeting partnership and promote the expansion of affordable community housing opportunities integrated with long term supports.

Department of Health and Human Services is seeing additional tangible results from collective, cross disability housing advocacy. The 2006 and 2007 legislative budgets included substantial increases in funding to expand the Department of Health and Human Services–Housing Finance Agency partnership in addressing the housing needs of extremely low income persons with disabilities, the Housing 400 Initiative. In total, $18.4 million of capital funding to the N. Housing Trust Fund and $5.2 million of recurring funds for the Key Program have been appropriated to expand production of a range of independent and supportive housing units targeted to persons with disabilities and incomes as low as SSI.

While these are housing resources that were not available five years ago, the continually shrinking supply of federally subsidized housing resources means that Money Follows the

Person participants will be challenged to locate safe, decent, accessible and affordable housing in communities of their choice. Participants will, however, be able to avail themselves of significant improvements developed as part of the Real Choice Grant in the available tools and capacity of supportive service providers to assist them in finding and accessing housing resources.

These tools include county specific listings of affordable housing resources for each of North Carolina's 100 counties and an Affordable Housing Primer that gives basic information about navigating the affordable housing system including North Carolina specific contact information for housing programs across the state. These tools are now posted and updated on the website of the North Carolina Housing Coalition. North Carolina has also implemented an online housing search tool, www.NCHousingSearch.org, which is currently operational, and marketing to landlords. Searchable by a number of criteria (location, proximity of transportation, accessibility, etc.), this service is designed to provide real time information, posted by participating landlords, of units available for rent across the state. A statewide inventory of affordable housing resources is in the development stage.

Service providers working with Money Follows the Person participants will be invited to join one of 30 Housing Support Committees (Housing Support Committees) organized across the state. Access to the Housing Credit and Housing 400 Initiative units is managed at the local level by the Housing Support Committee, a collaborative of human service providers who have come together to make referrals to these new housing opportunities and assure tenants' have access to the ongoing supportive service they may need to live successfully in the community. As each new property is funded, a Local Lead Agency (LLA) is identified who will represent the local Housing Support Committee in dealing with property management. Members of the Housing Support Committee make referrals to the property owner and the LLA maintains a waiting list, in the event of turnover, once the specified number of Targeted units is occupied. The Housing Support Committee is also knowledgeable about other affordable resources, as well as the range of community services and providers available in their community.

North Carolina has 131 public housing agencies (PHAs) or Housing Choice Voucher administering agents. The availability and quality of public housing units varies across locations. The availability of Housing Choice Vouchers is more limited, with many locations having closed waiting lists or waits up to two and three years. Over the past few years, most, if not all, public housing agencies have been approached by the disability community, through the Housing Support Committee or other efforts, about re-establishing a preference for persons with disabilities. While this has been successful in some areas, in others it has not, where public housing agencies are responding to pressure on their budgets to direct assistance to higher income levels. Efforts to engage public housing agency's for the benefit of the Money Follows the Person target populations will continue.

Access to other qualified residences, community based settings housing no more than four individuals, will likely require providers who are willing to re-tool exiting residential settings licensed under North Carolina facility rules. While both Supervised Living, licensed under mental health, developmental disabilities and substance abuse rules, and Family Care Homes, North Carolina's smaller board and care facilities, may serve as few as two individuals, the majority of these settings are currently serving the maximum number allowed by the rules, six persons in Supervised Living and seven in Family Care.

Qualified Residences

Refer to **Attachment E** for a list of defined qualified residences.

Continuity of Care Post Demonstration

The following will be used to promote the effective outcomes of the demonstration and to ensure continuity of care.

Managed Care/Freedom of Choice (Section 1915b)
Evidence for each participant will be the written documentation of choice of receiving services within an Intermediate Care Facility-Mental Retardation facility or receiving home and community based services. Documentation will be included prior to transition to the community and will be maintained within the participant record as part of the certification process to the Waiver program. Within the choice document, it will provide a clear and informed choice for the consumer and or legal guardian. Fair Hearing documentation will also be included upon the beneficiary choice and informed consent determination. Review of record will occur by the Local Management Entity within the first three months of community living.

Home and Community Based (Section 1915c)
In the waiver for individuals who have eligibility for the CAP/MR-DD, there will be a specified number of slots assigned to eligible participants to the Money Follows the Person Demonstration Grant project. These slots will be managed by the Waiver Program Manager at Department of Mental Health/Developmental Disabilities/Substance Abuse Services; be used for those who are currently are in either a State Developmental Disabilities Center or a Community Intermediate Care Facility-Mental Retardation and be used only for participants who have their own guardianship and request community placement or those whose legal guardians have requested community placement.

Research and Demonstration (Section 1115)
Not applicable.

State Plan and Plan Amendments
North Carolina will not utilize the State Plan Amendment.

CAP/Choice
(3/20/08 - BJ will provide)

CAP/DA
(3/20/08 - BJ will provide)

Organization and Administration

(Lorie will provide)

Organizational Structure
Staffing Plan
Billing and Reimbursement Procedures

Evaluation

Evaluation is not a required component of the Money Follows the Person Operational Protocol. Although states may propose to evaluate unique design elements from their proposed Money Follows the Person programs, the state of North Carolina has opted not to include its own evaluation. The State will utilize data collected by the national evaluator (Mathematica, Inc.) for the Money Follows the Person evaluation as indicators of the project's effectiveness.

Final Project Budget

Budget Presentation and Narrative

North Carolina's budget projections for this grant are based on the anticipated enrollment of 552 individuals for the 2007-2011 project period. The State utilized existing data and experience gained from its earlier nursing home transition grant and from its Case Management System to estimate the number of individuals that would likely be eligible under the terms of the grant. The State based its cost allocations on the uniform transition of the 552 individuals over each month of the implementation grant.

Medicaid Administrative Costs

The State has hired a full time Grant Project Director who is responsible for grant's operations. The State projects hiring a Project Transition Director with a base salary of approximately $57,979 and the Administrative Assistant with a base salary of approximately $26,825. The two salaries include related fringe benefits of 33% for each position. In addition, the State is projecting ancillary expenditures including travel, equipment, supplies, brochures, and postage to be approximately $60,000 over the life of the grant. There are no planned contractual costs, including consultant contracts. The State projects the total administrative expenditures to be approximately $889,359 over the life of the grant.

Qualified Home and Community-Based Services

The State also projected the 552 individuals would need to utilize more qualified Home and Community-based services due to these individuals having previously resided in a qualified nursing facility for at least a six-month period. It has been the States experience that one of the larger impediments to transitioning to the community has been a lack of community support. In response to this the state has budgeted for a larger percentage of services being utilized.

Home and Community-based Demonstration Services

The State is up-dating all CAP waivers to incorporate the new demonstration services that will be used to use to support individuals in their efforts to access services in the community.
These services are mandated to be imposed no later than March 2010. The CAP/MR-DD services will be bundled, which are projected to be utilized by more than 50% of the MFP target population, and will address an important gap in the State's long term system. Based on previous experience with the nursing home transition grant it is the State's experience that this service will be a resource for community services and assist with education and training of the individual community supports for those choosing to transition from the institutional setting.

Supplemental Demonstration Services

The state is projecting that a less than 10% of the individuals to be served through the MFP grant will utilize the State's supplemental demonstration service of adaptive devices. From pervious experience the State has determined a need for adaptive devices including lift chairs, automatic door openers and other electronic assertive devices.

Money Follows the Person Budget Form

See Appendix ?

Optional Components

The following reporting requirements are optional. North Carolina will provide the necessary information as required,

- Web-based reporting
- Finder files and MSIS Data Extract Files
- Maintenance of Effort (MOE)
- Financial Reporting – SF-269, SF272
- Money Follows the Person Financial Reporting Form

Attachment A

Community Options Interest Survey
CAP/MR-DD

Guardian: _____ Resident: _____

Surveyor: _____ Date of Survey: _____

Hello. My name is _____ and I am a _____ at the _____ Center. We are calling all of the residents [**or the legal guardians**] to gather information for the Center for planning purposes. It will only take a few minutes to complete the survey. Is this a convenient time for you or would it be better to arrange another time to call back?

[**If yes, proceed with survey. If no, schedule a date and time to call again.**]

The _____ Center is committed to exploring opportunities for individuals to live in community homes with the supports they need to be safe, happy, and healthy. We want input from you as a resident [**or as _____'s legal guardian**] on your interest in community living.

If there were an option for you [**or for the individual in your guardianship**] to relocate to a community living arrangement, what circumstances or conditions would you [**or for the individual in your guardianship**] need to consider before making a decision to live in the community?

a. **The location of the community arrangement**

Community located close to family	___Yes ___No
A particular region in the state	_____
A particular county in the state	_____

b. **The type of living arrangement**

Home owned or leased by you or a family member	___Yes ___No
Apartment leased by you or a family member	___Yes ___No
Public housing	___Yes ___No
Assisted living with individual living, sleeping, bathing, and cooking areas	___Yes ___No
Community-based residence with fewer than four unrelated individual's	___Yes ___No

c. **Services and supports**

Personal emergency response services	___Yes ___No
Respite care	___Yes ___No
In-home aide services	___Yes ___No
Preparation and delivery of meals	___Yes ___No
Specialized equipment or supplies	___Yes ___No
Consumer-directed care advisory	___Yes ___No
Consumer-directed financial management	___Yes ___No
Augmentative communications	___Yes ___No
Home modifications	___Yes ___No
Non-medical transportation	___Yes ___No
Specialized consultative services	___Yes ___No
Home modifications	___Yes ___No
Vehicle adaptations	___Yes ___No
Transition expenses	___Yes ___No

d. Need immediate and consistent access to quality healthcare? ___Yes ___No

e. Behavioral supports and crisis services that meet your needs? ___Yes ___No

Surveyor's Comments:

Attachment B

Contract of Responsibility

I, _____(name) [or my legal guardian_____]

understand that I am being served by Transition specialist,

_____ (name) from the _____ (organization).

In receiving services from this organization, I will develop an independent living plan. The plan will include my goals and steps for reaching my goals. The plan will be based on my goals and choices, an independent living evaluation and other pertinent information. I agree to work in partnership with the organization to achieve my goals in the manner and time agreed upon by the staff person and me. Anytime I choose to end this relationship, I may do so by notifying the staff member of my decision in writing or another alternative format. Failure to meet my responsibilities in the plan shall be cause for the organization either to revise the plan or terminate the contract.

I understand that the organization and its employees, working to achieve the objectives of the plan, are not themselves making medical decisions or making decisions about the transition process for me. The organization and its employees are not responsible for any consequences to my health resulting from a transition to community-based care and/or a residential setting.

The risks of transitioning to the community have been explained to me.

I understand that the _____ staff person is obligated in aiding the transition from the initial planning stage through the actual transition and follow up (can be up to 365 days) but is not going to act as my permanent case manager.

I authorize the _____staff person to share information that is reasonably necessary to assist me in achieving my goals with members of the transition team. I can revoke this consent at any time.

Consumer signature _____Date_____

Guardian signature (if applicable) _____Date_____

Witness signature _____Date_____

Family member _____Date_____

Attachment C

The North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) Introduces...

The *Money Follows the Person Demonstration Grant project*!

What does "Money Follows the Person" mean?
When people who are elderly or have disabilities need personal assistance, they often have to go to a nursing home or an institution in order for Medicaid to pay for it. However, many folks would prefer to receive these services in their own homes and in their own communities.

Money Follows the Person is the term describing the practice of Medicaid allowing these same people to move *out* of nursing homes and institutions and receive the assistance they need to live in their homes and communities. Thus, the **money** for the assistance **follows** the **person** out of the nursing home or institution and into their homes and communities.

Why is this called a "Demonstration Project?"
The federal government is awarding extra funding and assistance to states wishing to **demonstrate** how state Medicaid agencies can effectively develop "Money Follows the Person" practices. This funding is time-limited and each state must agree to move people from institutional settings to home and community-based settings.

North Carolina was awarded its Money Follows the Person Demonstration Grant in May 2007.

What is the purpose of North Carolina's Money Follows the Person Demonstration Grant Project?
Reorganizing Medicaid services to enable **money** to **follow** people out of institutions is a very complex process. It involves shifting state policies, rules and regulations, adjusting Medicaid funding streams, and supporting local communities so people who are elderly or have disabilities can come home.

The purpose of the Money Follows the Person Demonstration Grant is to provide the state with additional funding and support so it can assist 552 people to move from institutional settings to home and community-based settings and also ensure this continues after the grant ends.

Who will benefit from the Money Follows the Person Demonstration Grant project?
During the course of the Project, NC wants to support **at least** 552 people who are currently in nursing homes or institutions to move from institutional care to home and community-based services. These people will be made up of senior citizens, people with

developmental disabilities, people with physical disabilities and people with mental illness.

How long will the Money Follows the Person Demonstration Grant project last?
Until September 30, 2011.

What happens when the Money Follows the Person Demonstration Grant project is over?
Hopefully, the state will have the structures and supports in place to begin supporting **anyone** who is eligible to receive services in a nursing home or institution to receive those same services in their homes and communities.

How is the Money Follows the Person Demonstration Grant project different from other Money Follows the Person advocacy efforts in NC?
In addition to NC's Money Follows the Person Demonstration Grant project, there is also a Money Follows the Person grass-roots advocacy effort. This grass-roots advocacy effort is promoting *state legislation* that will allow anyone who is eligible to receive personal care in a nursing home or institution to receive those same services in their homes and communities. The Money Follows the Person Demonstration Grant project *(a federally funded initiative)* targets 552 people in NC, while the Money Follows the Person grassroots effort is advocating for everyone to have this option.

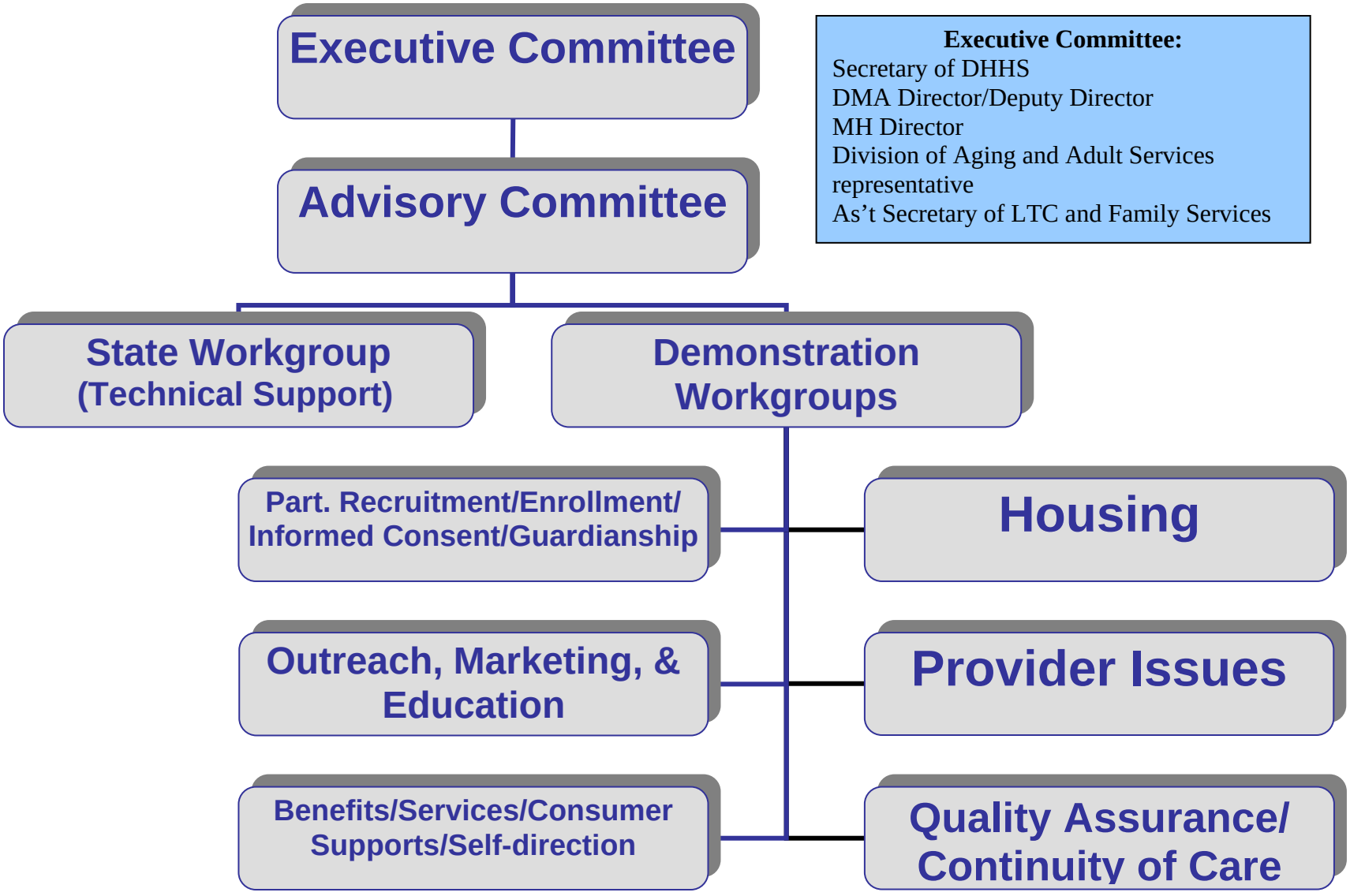
The two efforts have the same goal: to support people to live in their homes and communities.

Who do I contact if I want more information on the Money Follows the Person Demonstration Grant project?
Linda Hicks, Project Director
919-855-4260 or linda.m.hicks@ncmail.net

Is there a website where I can learn more about North Carolina's Money Follows the Person Demonstration Grant project?
The NC Division of Medical Assistance has created a site for the Money Follows the Person Demonstration Grant project. Please visit http://www.ncmfp.com.

The North Carolina Disability Action Network (NCDAN) is following the Money Follows the Person Demonstration Grant project's progress and has lots of useful information including a link to the site above. NCDAN's website: www.ncdan.com

Attachment D



Executive Committee:
Secretary of DHHS
DMA Director/Deputy Director
MH Director
Division of Aging and Adult Services representative
As't Secretary of LTC and Family Services

Each Demonstration workgroup has a State and non-State employee facilitator and is composed of providers and consumers.

Attachment E

Qualified Residences for North Carolina Money Follows the Person Participants				
Type of Qualified Residence	**Number of Each Type of Qualified Residences***	**State of Definition Housing Settings & Number of Each**	**Number of Each Settings***	**How Regulated**
Home owned or leased by individual's family member		• Home leased by individual or family • Home owned by individual • Home owned by family		• Lease with landlord • N/A • N/A
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing, & cooking areas over which the individual or the individual's family has domain & control.		• Apartment building • Assisted living: multi-unit assisted housing with services • Public housing units • Rural Development Apartment • Housing Credit unit • Supportive housing unit		• Lease with private landlord • Lease with private landlord and HC Voucher • Lease with Public Housing Agency • Lease with RD • Lease with landlord w/HC Voucher • Lease with landlord and Key assistance • Lease with landlord
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside (Non-Intermediate Care Facility-Mental Retardation facility).		• Supervised Living • Alternative Family Living • Family Care Home		• State122C licensing regulations • 131D licensing regulations

***To be determined as individuals are transitioned**

ATTACHMENT ?

North Carolina Money Follows the Person Rebalancing Demonstration Preliminary Budget						
Demonstration Personnel						
	CY 2007	**CY 2008**	**CY 2009**	**CY 2010**	**CY 2011**	**TOTAL**
Project Director	$57,979	$59,428	$60,914	$62,437	$63,998	304,756
Transition Coordinator	$57,979	$59,428	$60,914	$62,437	$63,998	304,756
Admin Assistant	$26,825	$27,496	$28,183	$28,888	$29,610	141,002
Fringe Benefits	$26,415	$27,075	$27,752	$28,446	$29,157	138,845
TOTAL	$169,198	$173,427	$177,763	$182,208	$186,763	$889,359
Other Administrative						
MMIS Configuration	$1,000,000					$1,000,000
Total Administrative						$1,889,359

ATTACHMENT

LINDA M. HICKS

4325 Whisperwood Drive
Raleigh, North Carolina 27616
919-412-4310
lindamhicks@gmail.com

EXPERIENCE

March 25, 2008 – present Dept. of Health and Human Services Raleigh, NC

Project Director

- Manage Money Follows the Person demonstration grant for the state of North Carolina.

May 15, 2005 – March 21, 2008 Durham's Partnership for Children Durham, NC

More at Four Program Manager

- Coordinated all aspects of More at Four (MAF) program in Durham county.
- Monitored compliance to State and local MAF Guidelines and Requirements.
- Coordinated collaborative efforts with community agencies serving children and families which have an impact on MAF program (health agencies, family support agencies, local Head Start grantee, etc.).
- Coordinated training and technical assistance.
- Supervised staff of two fulltime employees, social work intern (when applicable), temporary employees, and contract personnel.
- Strategic planning for MAF program, county pre-kindergarten programs, and the organization based on results of evaluations and needs assessments.

May 2001 – May 2005 East Coast Migrant Head Start Project Raleigh, NC

Program Monitor

- Monitored Delegate Agencies and Direct Service programs in adherence to the Head Start Performance Standards and contract compliance (Delegate Agencies).
- Strategic planning for organization based on monitoring results, evaluations, and needs assessments (conducted annually).
- Provided training and technical assistance for program self-assessment, monitoring systems, and development of department manuals, policies and procedures.
- Assisted in the design and content of the departmental Monitoring manual.

50% travel along the East Coast of USA.

Sept. 1999 - April 2001 Wake County Smart Start Raleigh, NC

Quality Enhancement Specialist

- Provided early childhood technical assistance to childcare programs in Wake County.
- Coordinated quarterly childcare conferences hosted by agency; led workshops.

- Evaluated programs using the ITERS and ECERS.

EDUCATION

1979–1983 University of Montevallo Montevallo, AL
- B.S., Early Childhood Education.

2002 – October 2003 University of Phoenix, Online Phoenix, AR
- M.A., Organizational Management.

ACCOMPLISHMENTS, OTHER

Obtained NAEYC accreditation while at Washington St. United Methodist Church Child Development Center (1995)

Obtained CITA accreditation for Garner, NC center while at Sylvan Learning Center (1999)

Trained trainer in the TouchPoints model (T. Berry Brazelton, MD) (2000)

Environmental Rating Scales (ECERS, ITERS) training - 3-day course (2001)

Office of Head Start PRISM Reviewer (2002 – present)

Facilitator – Wake Education Summit (2004); Durham Public Education Network (2007) and various community functions related to position at Durham's Partnership for Children

Trained trainer (2 day course) – Foundations: NC Early Learning Standards (2006)

List of Acronyms

Acronym	Full description
CMS	Center for Medicaid and Medicare
CAP/Choice	Community Alternatives Program/Choice
CAP/DA	Community Alternatives Program/Disabled Adults
CAP/MR-DD	Community Alternatives Program/Mentally Retarded/Developmental Disabled

Attachment ?

Self-Direction

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development**. Specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

X	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
X	Case Manager. *Specify qualifications*:
X	Social Worker. *Specify qualifications:*
	Social Worker I or higher as specified by the NC Office of State Personnel. Social Worker I requires a bachelor's degree n a human services field from an accredited college or university; bachelor's degree from an accredited college or university and one year directly related experience.
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	All lead agencies have a freedom of choice policy and freedom of choice documents that are required to be signed by participants after plan of care development is completed. These documents explain the participant's choice to choose from any qualified provider for their traditional services at any time, upon request. Additionally, participants in this waiver have the extra responsibility of choosing and directing other specific waiver services (e.g. personal assistant, respite, supplies, etc.). A backup plan is developed to assure that the needed assistance will be provided if any key supports identified in the plan are temporarily unavailable. Participants are also informed of due process rights if they disagree with any decisions made by the care advisor. Consultants from DMA conduct agency reviews and review plans. Additional monitoring of services is given in situations where the entity providing care advisement also provides another waiver service. This occurs sometimes in more rural regions of North Carolina.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The care advisor assists the participant in assessing individual needs and developing a plan of care including a participant-directed budget. The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate. The care advisor monitors the provision of care and expenditures and maintains contact with the participant to assure the needed care is being provided. The care advisor is also responsible for identifying the need for a representative and assuring that representatives are capable of meeting the needs of the participant.

The role of participants is greater in CAP/Choice than in the traditional program CAP/DA. In CAP/CHOICE participants have more control over resources. With this increased control comes increased responsibility. The key responsibilities of the participant or designated representative are:

- Develop a plan of care with assistance/support from the care advisor;
- Recruit, hire, and manage personal assistant and other individual providers of participant-directed services;
- Prepare an outline of duties and work schedule for personal assistant;
- Negotiate salary and benefits with the assistant;
- Notify assistant of any changes in schedule in a timely manner;
- Train and evaluate personal assistant;
- Negotiate reimbursement or payment rates with individual providers;
- Develop a back-up/emergency plan (alternative caregivers);
- Serve as employer of record for personal assistant;
- Verify accuracy of documentation or provide documentation, as appropriate, to financial manager regarding services provided;
- Report concerns to care advisor about service delivery or representative that affect health and well-being; and,
- Uphold all program agreements as written.

d. Service Plan Development Process In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)The following individuals are responsible for the preparation of the plans of care:
The Participant and the care advisor.

(b)A registered nurse and social worker team meet with the applicant/significant others to conduct an assessment and determine the need for a representative.

(c)During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue.

(d) The plan of care and supporting documents are reviewed by and approved by someone at the lead agency other than the care advisor, after agreement and signature by the participant and/or representative and care advisor. Focus is on the ability to meet the identified needs of the participant within the budget limitations whilst maintaining the participant's health, safety and well-being.

The contracted QA/QI agency as well as DMA consultants are able to perform ongoing review of plans of care as well as more in-depth reviews on site monitoring visits.

(e)The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget according to state requirements.

(f)The care advisor will assist with development of plan of care and emergency/back-up plan; provide information and skills training to participant/participant's representative; provide worker orientation to participant-directed care; monitor plan of care for quality assurance purposes.
Also, waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed.

(g) Plans of care are updated as many times as warranted by a change in health status, need, etc. However, re-evaluations of the level of care are required at least annually or sooner if there are indications that the participant's condition/level of care has changed. A new assessment and plan of care are required at the same time as the annual level of care re-evaluation.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The state has procedures to promote family or individual preferences and selections. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Participants and/or designated representative will be fully involved in the needs assessment process and will select personal assistants based on their (vs. agency) preferences. The participant will train the assistant and determine whether task competencies are met. In assuming these responsibilities, the participant necessarily takes on risk that was previously assumed by provider agencies and program managers. Participants who participate in this program will therefore enter into agreements with the lead agencies which outline rights, risk and responsibilities.

A back-up plan is also developed to assure that the needed assistance will be provided if any key supports identified in the Plan are temporarily unavailable. The Care Advisor provides the information and skills training needed to manage one's own care in the areas of rights and responsibilities of both the Consumer and Worker; recruiting and hiring workers; developing schedules and outlining duties; supervising and evaluating workers; reporting on personal assistance expenditures; and other relevant information and training.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

The care advisor is available to the participant throughout the planning and service delivery process to provide skills training and information relevant to home care, worker employment, etc. The amount of assistance from the advisor will vary from participant to participant depending upon need. Care advisors are to make available to the participant a comprehensive list of qualified providers in, or having the ability to provide services in the applicable service area. This list will be made available upon the participant's or the representative's request.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

The same basic care planning process currently used in the elderly/disabled HCBS waiver, CAP/DA, will apply to CAP/Choice with the addition that the process will be guided by principles of participant-directed care. Currently the steps in the entry process are:
1.During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue;
2.A health care professional along with the planning team meet with the applicant/significant others to conduct an assessment and determine the need for a representative;
3.The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget;
4.The care advisor submits the plan to the designated position in the lead agency for approval.
5.Once approval is obtained, services are implemented by the care advisor or participant, as specified in the plan; and,
6.Post-approval reviews by CCME QA processes and DMA consultants are conducted as requested or Plan is sent to Division of Medical Assistance.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
X	Other (*specify):*
	Lead agencies in each county. Note: due to the current use of the AQUIP, an automated assessment and plan of care system, DMA has access to electronic records via a secured website at any time.

II. Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a)Care advisors and CAP/Choice program consultants ensure that waiver services are furnished in accordance with the plan of care by maintaining regular contact with the participant and/or designated representative. Monthly contact is required via telephone and/or home visit. Home visits are required a minimum of quarterly.

(b) & (c)Method and Frequency of Oversight/Monitoring: Waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed. These visits occur every 12-18 months.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	(a)Adequate standards for all types of providers that furnish services under the waiver. (b)Assurance that applicable state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements will be met on the date that the services are furnished. (c)Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities. Participants are provided the freedom of choice amongst providers and are educated on all due process rights. DMA consultants provide technical assistance and review this information on request and/or at program site visits.

III. Overview of Self-Direction

a. Description of Self-Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

(a)Under CAP/Choice, participants will be able to:
• Choose (hire) the personal assistant who will provide their care;
• Train, supervise and evaluate the worker;
• Negotiate the rate of pay and other benefits;
• Release the worker should this become necessary;
• Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3); and,
• Engage in a cooperative working arrangement with a financial manager who will pay the client's worker, handle federal/state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the participant.

(b)The program affords increased participant choice and independence in meeting home care needs and increasing satisfaction with long term supports. To be eligible for CAP/Choice an individual must:
• Live in the geographic areas where CAP/Choice is available;
• Meet basic criteria to be assessed for HCBS waiver participation e.g., at risk of institutional care;
• Be eligible for Medicaid; and,
• Understand the rights and responsibilities of directing one's own plan of care and be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility

(c)DMA, Local Lead Agencies, Financial Management Agencies, Waiver Service Providers and other providers interacting with and participating in the participant's plan of care.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
X	**Both Authorities.** The demonstration provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

X	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

X	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a)Under CAP/Choice, participants will be able to:
•Choose (hire) the personal assistant who will provide their care
•Train, supervise and evaluate the worker
•Negotiate the rate of pay and other benefits
•Release the worker should this become necessary
•Select individual providers and direct reimbursement for several other waiver services
•Engage in a cooperative working arrangement with a financial manager who will pay the client's worker; handle federal/state taxes and other payroll or benefits related to the employment of the worker; and reimburse other service providers under the direction of the participant

(b)The lead agency will give each HCBS waiver applicant a choice between the traditional program and the new participant-directed model. In making this decision a participant/representative will be educated on the benefits and responsibilities of the participant-directed model.

(c)The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate prior to implementation of participant-directed services. The advisor monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided on a continuing basis. Care Advisors will participate in training and have access to materials with a participant-directed focus.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of demonstration services by a representative *(select one)*:

○	The State does not provide for the direction of demonstration services by a representative.	
X	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: *(check each that applies)*:	
	X	Demonstration services may be directed by a legal representative of the participant.
	X	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		The representative may NOT also be the paid caregiver (i.e. personal assistant) for the participant. The representative cannot be paid for the service and must meet the following requirements: • demonstrate knowledge and understanding of the participant's needs and preferences; • agree to a predetermined level of contact with the participant; • be willing to comply with program requirements; • be at least 18 years of age; and, • be approved by the participant to act in this capacity. The Care Advisor plays a significant role in identifying the need for a representative and assuring that the representative meets the criteria outlined above. Additionally, the care advisor, as part of ongoing monitoring activities, assures that the representative continues to act in the best interest of the participant.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each demonstration service. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Respite Services (In-Home)	X	X
Financial Management Services	X	X
Home Modifications and Mobility Aids	X	X
Consumer-Directed Goods and Services	X	X
Personal Assistant Services	X	X
Waiver Supplies	X	X

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one:*

X	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	X	Governmental entities
	X	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. S*elect one*:

X	FMS are covered as a Demonstration service	Fill out i. through iv. below:
○	FMS are provided as an administrative activity. Fill out i. through iv. below*:*	

i. **Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal Employer Agency

ii. **Payment for FMS**. Specify how FMS entities are compensated for the activities that they perform:

FM is billed in units of 15 minutes. FM is allowed to bill up to 6 units for the startup month and up to 4 units per month thereafter. Total units in a year cannot exceed 50.

iii. **Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

X	Assist participant in verifying support worker citizenship status
X	Collect and process timesheets of support workers
X	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
X	Other *(specify):*

Financial Management Services are provided to assure that participant-directed funds outlined in individual plans of care are managed and distributed as intended. The Financial Manager (FM) files claims through the MMIS for participant-directed goods and services and reimburses individual providers. The FM deducts all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks. The FM entity is responsible for maintaining separate accounts on each participant's services funds and producing expenditure reports as required by the State Medicaid agency. The FM also provides reports on at least a monthly basis to the participant. The FM conducts criminal background checks and age verification on personal assistants as requested by the participant.

Supports furnished when the participant exercises budget authority:

☐	Maintain a separate account for each participant's self-directed budget
☐	Track and report participant funds, disbursements and the balance of participant funds
☐	Process and pay invoices for goods and services approved in the service plan
☐	Provide participant with periodic reports of expenditures and the status of the self-directed budget
☐	Other services and supports *(specify)*:

Additional functions/activities:

☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
☐	Other *(specify):*

	iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:*
X	**Demonstration Service Coverage**. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled: **Care Advisory, Financial Management Services**
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one).*

X	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
	1) North Carolina's Long Term Care Ombudsman Program consists of state and regional ombudsmen who help residents of long term care facilities to exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff about rights and help resolve grievances between residents/families and facilities. The regional ombudsmen, who are located within Area Agencies on Aging, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (N.C.G.S. 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in long term care facilities. There are over 1,300 such volunteers statewide, with committees in each county. The State Ombudsman is Sharon Wilder. The services provided by the Ombudsman Program include: A. Answering questions and giving guidance about the long term care system. An ombudsman will:

	• explain long term care options. • give pointers on how to select a long term care facility provide information on specific facilities (such as the latest and past certification reports and complaint information). • explain residents' rights and other federal and state laws and regulations affecting long term care facilities and residents. • give guidance on the Medicaid and Medicare programs--specifically qualification criteria, application procedures and what services these programs cover. • give guidance on such matters such as powers of attorney, living wills and guardianship. B. Educating community groups and long term care providers on various topics such as residents' rights, restraint use, care planning, activities and new laws. C. Investigating and assessing matters to help families, residents and families resolve concerns and problems. Common areas of complaints include: • medical and personal services being provided to residents such as problems with medication, nutrition and hygiene. • financial concerns such as handling of residents' funds, Medicare, Medicaid, and Social Security. • rights of residents, such as the right to be treated with courtesy and to have individual requests and preferences respected. • nursing home administrative decisions, such as admission to or discharge from a facility. D. Working with appropriate regulatory agencies and referring individuals to such agencies when resolutions of issues are not possible through the Ombudsman Program alone. E. Raising long term care issues of concern to policymakers. 2) County Adult Protective Service programs are required to investigate and act upon any allegations of abuse, neglect, and exploitation of the participant. 3) The participant has the opportunity to self-advocate through participation in local non-profit advocacy groups, such as Centers for Independent Living, the Participant Task Forces of various state programs and initiatives (e.g. - Rebalancing Grant, Money Follows the Person Demonstration, Systems Transformation Grant, etc), and input into the State Independent Living Council.
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A Care advisor works with the participant to transfer to an alternate waiver or other state plan service(s) and monitors health and safety until the new service is fully implemented.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the care advisor will work with the participant to resolve them. If they cannot be resolved, the participant will be removed from the program and assessed for the traditional HCBS program, CAP/DA. Care advisors/lead agencies will consult with DMA program consultants prior to taking ant action.

Participants who demonstrate the inability to self-direct waiver services, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, will be required to select a representative to assist them with the responsibilities of self-direction. If a participant refuses to select a representative or if participant loses a representative and cannot locate a replacement, they will be required to transfer to another waiver program that has traditional agency oversight. Care advisors will assist the participant in the transition. Participants are given due process rights for any changes in service and/or termination/removal of a service/program.

Note: Participants may also voluntarily terminate participant direction in favor of returning to CAP/DA.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Demonstration Year	**Number of Participants**	**Number of Participants**
Year 1 (2008)		0
Year 2 (2009)		3
Year 3 (2010)		5
Year 4 (2011)		7
Year 5		N/A

Participant Employer

a. Participant – Employer Authority *(Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the demonstration. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
X	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. *Check the decision making authorities that participants exercise*:

X	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The financial manager does this upon request of the participant. The cost is incorporated into the financial management reimbursement.
X	Specify additional staff qualifications based on participant needs and preferences
X	Determine staff duties consistent with the service specifications
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

X	Reallocate funds among services included in the budget
X	Determine the amount paid for services within the State's established limits
X	Substitute service providers
X	Schedule the provision of services
X	Specify additional service provider qualifications
X	Specify how services are provided,
☐	Identify service providers and refer for provider enrollment
X	Authorize payment for demonstration goods and services
X	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Methodology for Calculation of Individual/Participant-Directed Budget:

Budgets will be calculated based on the methodology in place for the CAP/DA waiver currently serving the elderly/disabled. The process involves an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each service is calculated. The cost of all services cannot exceed the average per capita cost to Medicaid of nursing facility care. Additionally, there is monthly individual budget limit, designated by level of care, that cannot be exceeded.

The budget will contain both agency and participant-directed services, as outlined below. Those designated as participant-directed will constitute the individual budget to be directed by the participant.

Agency-Directed:
Adult Day Health Care
Care Advice
Financial Management
In-Home Aide
Institutional Respite
Preparation & Delivery of Meals
Telephone Alert

Participant-Directed:
Participant-Designated Goods & Services (additional limit of $600/year)
Home Modifications and Mobility Aids* (additional limit of $1500/year)

Personal Assistant
Respite (In-Home)
Waiver Supplies*
*Indicates service may be either participant or agency directed

It is recognized that actual utilization of services authorized does not equate to 100% - for example, participants are hospitalized, aides miss visits and substitutes are not available. (*NC DMA requires a minimum of monthly monitoring of all waiver services, including the participant's emergency back-up plan. If it is determined the participant's needs are not being met the plan of care is modified to address these needs. New supports and services are identified and put in place to meet these needs. If these needs continue to go unmet or the participant's health and well-being are at risk other programs may be identified that better serve the participant.) Based on findings of the National Cash & Counseling Demonstration, at least 10 to 20% of personal care services authorized in the traditional delivery system are not used. In addition, many of the indirect costs which are built into the payment rates such as professional supervision and training of workers, office space, equipment, supplies, etc., are not applicable to the participant-directed model. Therefore, the maximum hourly rate for personal assistant services will be 10 to 20 percent lower than the current Medicaid personal care rate. Individuals may negotiate personal assistant payment rates lower than the maximum, thereby enabling them to set aside a portion of their budget for other services such as participant-designated goods and services which would increase independence.

Participants will have considerable flexibility in using funds designated as participant-directed. They will be able to substitute services and/or reschedule services within the budget without agency approval in certain cases.

The methodology will be explained to the participant/representative by the care advisor. The care advisor will point out both the added responsibilities if this model is selected and its benefits. The Individual/Participant-Directed Budget will be re-determined at least annually and more frequently depending on changes in the Participant’s situation. The methodology will be published in the operations manual for this program. All Medicaid policy and program manuals are available for public inspection.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant must be informed of the amount of the individual budget during and after the service plan development process. Participants may inquire about the balance of their account throughout waiver enrollment from his/her care advisor in addition to an annual evaluation.

iv. Participant Exercise of Budget Flexibility. *Select one:*

X	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	Participants have the authority to modify the timing of service delivery (ex. personal assistant hours). Otherwise, modifications to the participant-directed budget must be preceded by a change in the service plan after discussion with the care advisor.
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

At the local level plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified the care advisor will work with the participant to resolve them. If the problem(s) is not resolved, care advisors/local lead agencies will consult with DMA program consultants prior to taking any adverse action towards a participant.

Additionally, post-approval and post-payment reviews are conducted by CCME and DMA consultants.

Attachment ?

Quality Management Strategy – CAP/Choice
North Carolina Department of Health and Human Services
Division of Medical Assistance
(Excerpt from CAP/Choice Waiver Application Amendment, Appendix H)

I. Waiver Assurances

Level of Care Determination

North Carolina Medicaid requires that a level of care determination be made on all participants seeking home and community based services, including CAP/Choice, by using a standardized screening tool (currently the FL-2 form) for determining nursing facility level of care. Procedures exist to assure that individuals reflect nursing facility level of care after a complete assessment. Level of care is re-evaluated annually.

Each time a CAP/Choice participant assessment is completed in Automated Quality and Utilization Improvement Program (North Carolina's automated assessment, care planning and quality assurance tool implemented and maintained through state contract), certain information fields are analyzed resulting in a Resource Utilization Group Resource Utilization Group score being assigned to the participant. Since CAP/Choice participants must qualify for nursing facility level of care, the Resource Utilization Group score determined by Automated Quality and Utilization Improvement Program incorporates the same data elements as the national system.

Plan of Care

In North Carolina, the local lead agency assures that comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan. Local lead agencies assure that plans of care address all assessed needs and personal goals, either by waiver services or other means. Additionally, they assure that participants are afforded choice among service providers, that participants and/or their legal responsible party actively participate in the plan of care development, and that plans of care are updated or revised when warranted by changes in the waiver participant's needs.

Qualified Providers

For provider directed services, North Carolina Medicaid verifies that providers meet required licensing/certification standards and that staff have demonstrated competency to perform tasks. In addition to licensure standards, North Carolina Medicaid requires providers to submit a North Carolina Medicaid CAP/Choice Provider Enrollment Application. As part of the routine monitoring, Division of Medical Assistance reviews these providers to assure adherence to waiver requirements. For participant-directed services where the participant has "employer authority", the participant determines the qualifications of the individual provider.

Health and Welfare

Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant. Division of Medical Assistance has mandatory reporting requirements for all providers. North Carolina statutes require any person having reasonable cause to believe that a disabled adult is in need of protective services shall report (either orally or in writing) such information to the director of the county department of social services. County departments of social services must accept all reports alleging an abused, neglected or exploited disabled adult is in need of protective services.

In addition to reports of abuse, neglect or exploitation, critical events include decline in mental or physical health and/ or loss of informal support that effect the ability of the participant to self direct. If this occurs, care advisors reassess the participant's situation to determine whether the participant-directed option continues to be appropriate for the individual. Personal assistants and other direct workers who are in touch with the participant on a regular basis are instructed to report problems to the care advisor.

Administrative Authority

Division of Medical Assistance retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by local lead agencies and contracted entities. Specifically, state level CAP/Choice consultants conduct on site compliance reviews and Division of Medical Assistance contracts with The Carolinas Center for Medical Excellence for ongoing quality assurance and utilization management functions. CAP/Choice consultants have "real time" access to assessments, plans of care and quality indicators.

North Carolina Medicaid, through a contract with a fiscal agent, Electronic Data Systems Corporation, is responsible for ensuring that CAP/Choice claims are paid correctly. Electronic Data Systems Corporation has established edits and audits in the claims payment system to ensure payment is made in accordance with the approved methodology.

II. Roles and Responsibilities

Participant Role:
The role of participants is greater in CAP/Choice than in the traditional program, in that they have significantly more control over resources. With this increased control comes increased responsibility. The key responsibilities of the participant/designated representative are:

- Develop a plan of care with assistance/support from the care advisor
- Recruit, hire, and manage personal assistant and other individual providers of participant-directed services
- Prepare an outline of duties and work schedule for personal assistant
- Notify assistant of any changes in schedule in a timely manner
- Train and evaluate assistant
- Negotiate salaries and benefits of personal assistant employee
- Negotiate reimbursement or payment rates with individual providers
- Develop a back-up/emergency plan (alternative caregivers)
- Serve as employer of record for personal assistant

- Verify accuracy of documentation or provide documentation, as appropriate, to Financial Manager regarding services provided
- Report concerns to care advisor about service delivery or representative that affect health and well-being
- Uphold all program agreements as written

Representative Role:
The representative may be a family member, friend, legal guardian, other legally appointed representative, or income payee. The representative cannot be paid for the service and must meet the following requirements:

- Demonstrate knowledge and understanding of the participant's needs and preferences
- Agree to a predetermined level of contact with the participant
- Be willing to comply with program requirements
- Be at least 18 years of age
- Be approved by the participant to act in this capacity

Care Advisor Role:
The care advisor is a specialized case manager with an understanding of participant-directed care and the ability to facilitate rather than direct care planning and service delivery. Care advisors are registered nurses and social workers who meet the standards described in Appendix B.

- Assists the participant in assessing need and developing a plan of care including a participant-directed budget.
- Provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate.
- Monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided.
- Identifying the need for a representative and assuring that representatives meet the criteria outlined above.

Financial Manager Role:
The financial manager bills for participant-directed care services in the individual plan and disburses funds. The Financial Manager:

- Files claims through the MMIS
- Reimburses individual providers
- Makes required payroll deductions
- Conducts criminal background checks and verifies age and qualifications of personal assistants upon request.

State Role:
Division of Medical Assistance provides assurances of:

- Health, Safety and Well-Being
- Financial Accountability
- Evaluation of Need
- Choice of Alternative

III. Processes to Establish Priorities and Develop Strategies for Remediation and Improvement

A summary of the results of Division of Medical Assistance's monitoring of participant health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

Participant Role: In opting for self-directed care, the participant or representative assumes responsibility for contacting the care advisor if the participant believes his/her home care needs are not being met and safety and well-being are compromised. The care advisor makes a home visit to evaluate and assist – follow-up is immediate if the situation appears to be an emergency. Examples of situations that would trigger a participant report are: personal assistant repeatedly fails to show up as scheduled; personal assistant exhibits inappropriate behaviors or actions in the participant's presence; informal (non-paid) supports do not follow through with agreed upon assistance.

Care advisor Role:

- Provide training to the participant/designated representative on managing services. Orientation to the program is required and will cover participant-directed care principles/philosophy, worker and participant rights and responsibilities, and participation requirements. Additional training on topics such as worker recruitment, reimbursement/rate negotiations, communication and supervision, are also be available. Training may be informal, one-on-one, or conducted in a group setting.
- Review the participant's account at least monthly to monitor service provision. If significant deviations in actual vs. planned spending are occurring, contact with the participant is made to determine if a problem exists.
- Make monthly phone calls to the participant to inquire about any concerns or problems with service provision.
- Conduct a home visit quarterly to review service provision with the participant. Reassessments and plans of care are conducted annually and require home visits; these visits will count toward the quarterly visit requirement.

Division of Medical Assistance Role:

- Make on-site visits to review program activities. Division of Medical Assistance waiver program consultants currently conduct annual on-site reviews which include staff interviews, home visits, record reviews and review of operating procedures. The monitoring visits include review of participant accounts/funds disbursement against plans of care. A written report is generated and corrective actions for any problems identified are required. A summary report of findings and corrective actions will be submitted to CMS annually.
- Division of Medical Assistance and the lead agencies will work together to administer participant surveys. Questionnaires are sent to a random sample of participants along with a stamped, addressed return envelope. Performance of personal assistants, absences, turnover, supervision, concerns about any unmet needs and feedback on overall program operation are some of the areas that are addressed. Findings from the surveys are used for program improvement; any critical issues will be addressed immediately.

IV Compilation and Communication of Quality Management Information

North Carolina maintains its contract with the Carolinas Center for Medical Excellence for its quality assurance program review of the assessment, plan of care, service delivery procedures and claims processing for the waiver program. Carolinas Center for Medical Excellence provides an automated review of all CAP/DA and CAP/Choice participants using the Automated Quality and Utilization Improvement Program for Home and Community Based Services. The Automated Quality and Utilization Improvement Program is used to provide descriptive and longitudinal analysis of CAP/DA and CAP/Choice data. Once summary reports are established (on a monthly and quarterly basis), results of these reports for the quality assurance process are used by consulting staff to improve staff training and for identifying areas that indicate the need for consultative assistance to local programs.

The quality assurance review process continues to be a valuable tool for program improvement for both the local and lead administrative agencies and waiver program staff in Division of Medical Assistance Medicaid Agency. A sample of quality indicators include, but are not limited to:

- 30 Days Falls-Initial Assessment
- Unplanned Weight Loss-Initial Assessment
- Unplanned Weight Loss-Other Assessment
- Telephone Alert-Dementia or Alzheimer's
- Medication Confirmation
- Appropriate Use of Pads/Briefs
- Participant perceive they have Necessary Support and Services

Each county will be scored a percentage of each indicator. Each indicator will be measured on a scale from:

- Excellent (highest category)
- Good
- Fair
- Poor (lowest category)

V. Periodic Evaluation and Revision of the Quality Management Strategy

Division of Medical Assistance strategically evaluates its Quality Management System on an annual basis, in addition to providing on-going oversight and monitoring of its waiver program to ensure that each of the CMS assurances are continually met to improved the operation of the program. In strategizing its Quality Management System, reevaluation will involve families/individuals/representatives, providers, and other relevant stakeholders in the process of assessing its long-term goals and objectives. All relevant parties are given timely notice regarding upcoming reevaluations and other operational/procedural changes.

Quality Management Plan - 1915 (c) Waiver

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Introduction

The North Carolina public system for mental health, developmental disabilities, and substance abuse services is in the fourth year of a seven-year comprehensive restructuring and reform process that builds on reform legislation passed in 2001. Key components of this reform include:

- Consumer involvement at all levels,
- An emphasis on home and community based services, including CAP-MR/DD waiver design and development to:
  - Address the needs of individuals at the ICF-MR level of care in the community;
  - Provide services and supports that will enable individuals to move from ICF-MR state operated facilities and group homes into the community;
  - Better tailor services to individuals through a person centered approach to planning;
  - Offer service options that will facilitate individuals continuing to live in or return to live in private residences.
- Local accountability,
- Effective services and supports based on evidence-based practices,
- Data-driven and outcomes-focused decision making.

Design of the Quality Management System

Development of a Quality Management (QM) system for the CAP-MR/DD waiver and the system as a whole is one of the fundamental building blocks of Mental Health/Developmental Disabilities/Substance Abuse Services reform in North Carolina. It is the intent of the State MH/DD/SAS Plan that a QM system integrates and analyzes information from multiple sources and functions within the state service system. Quality Management processes must be accountable to all stakeholders and findings must be published, including the assessment of quality improvement activities. The specific objectives related to QM are:

- The Division will develop and execute a comprehensive QM system focusing on continuous quality improvement.
- The QM system will be outcome-based.
- Performance indicators for all levels of the system will be included in the QM process.
- The Division will develop measurement criteria for models of best practice to be included in the QM system.
- The Division will establish competency requirements for all segments of the mental health, developmental disabilities and substance abuse services workforce.
- The Division will manage a comprehensive training and education strategy to support the new QM system.

The redesigned QM system including the CAP-MR/DD waiver, will incorporate the Home and Community-Based Services (HCBS) Quality Framework. The QM Team has identified measures within each of the framework's domains that correspond to the goals of the State Plan and the CAP-MR/DD waiver. **Attachment 1** describes all the measures that DMH/DD/SAS is currently using or plans to use to measure system performance. Some of these measures are currently collected, analyzed, reported and reviewed as part of the LME Performance Contract. Mechanisms for regular collection, analysis and review of data on the other measures are currently being devised.

In addition to these measures designed specifically to support the QM plan, DMH/DD/SAS currently collects a wide range of data on service utilization and cost, consumer outcomes and satisfaction, and special projects. **Attachment 2** summarizes this data, which is available for use in the QM system.

Note that an early product of the work described here will be a State Quality Management Work Plan, detailing how DHHS will meet the QM requirements in the HCBS Draft Waiver application over the course of the 3-year period covered by this application. A key component of the efforts to create a comprehensive QM system is a Real Choice Systems Change Grant for QA/QI in HCBS awarded by CMS in 2003.

While the foundation of the QM system is already in place, the NC MH/DD/SAS is using this grant to complete the development and implementation of the information feedback loops that are critical to a system based on continuous quality improvement. The data and performance measures referenced above will be rolled into a cohesive process where information is used to assure quality and drive system improvement. Toward that end, work under the Systems Change Grant will accomplish the following goals:

- Evaluate the process and outcomes of transitioning consumers from institutional to home and community–based care through data collected in face-to-face interviews with transitioning consumers, using other consumers and family members as interviewers;
- Develop a comprehensive, coordinated system of Quality Improvement (QI) committees among provider agencies, local management entities and the NC Department of Health and Human Services (DHHS);
- Use the transition interview data and QI committees to pilot ways to improve service delivery and consumer outcomes and satisfaction through QI processes;
- Develop a long-term plan for expanding the focus of the QI committees to encompass other populations, services, and processes.

This document describes QA/QI processes that are currently taking place and future QA/QI processes in development are being planned as part of the CMS grant activities. The next section provides an overview of the organizational structure of the system and the responsibilities and activities of the primary entities involved in QM. The section also describes the specific quality assurance activities at the local and State level in regard to the CAP-MR/DD waiver. The remainder of the document is organized around the HCBS Quality Framework domains and the CMS regional review protocol components.

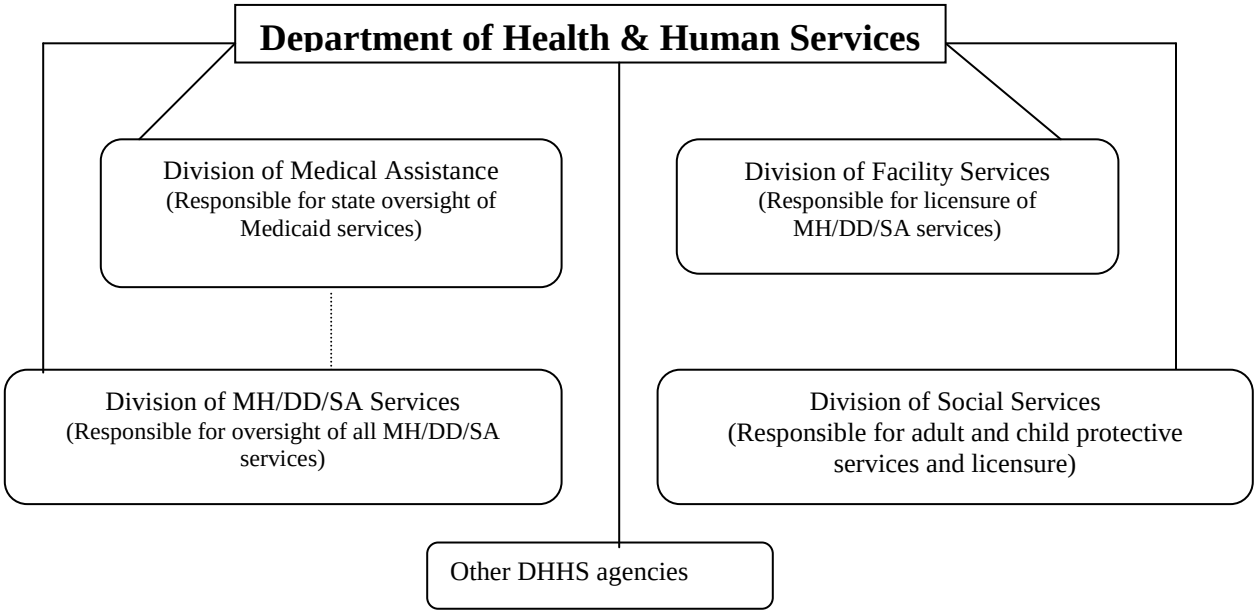
Organizational Context for Quality Management

A Quality Management System is built around a coordinated approach that defines, assigns, and interprets quality related activities across various cooperative entities. The following section describes those entities and their respective roles in the North Carolina system.

State Authority for the Waiver

According to federal and state guidelines, the NC Division of Medical Assistance (DMA) has responsibility for the overall operation of the HCBS waiver. The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the lead agency for overseeing the daily operations of this waiver. The two Divisions cooperate in the operation of the waiver program under a memorandum of understanding that delineates each Division's responsibilities. The Division of Facility Services (DFS), the Division of Social Services (DSS) and the Division of Aging and Adult Services (DOA) have legally mandated responsibilities for licensure of facilities (DFS) and for child (DSS) and adult protective services (DOA.). All of these Divisions are under the authority of the Department of Health and Human Services (DHHS). These relationships are depicted on the chart in Figure 1 below.

Figure 1: NC Department of Health and Human Services



Quality Assurance Responsibilities and Activities within the MH/DD/SAS System

Quality assurance and improvement responsibilities are shared across multiple entities. The system relies on each entity to fill a distinct role while interacting with the other entities. The North Carolina QM system starts with consumers and their families, and builds in a coordinated way to the highest levels of state oversight.

Consumers/Families

Consumers and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:

- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,
- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Local CFACs also participate in a "mystery shopper" evaluation of provider performance and response to service requests.

Providers

Provider agencies are responsible for:

- Licensure and certification,
- Providing Targeted Case Management,
- Development of person-centered plan of care,
- Development of internal quality improvement plans,
- Maintaining internal client rights committees.

Local Management Entities (LME)

The Local Management Entities (LME) are the local lead agencies for the counties they serve, and are responsible for the administration and operation of MR/DD waiver programs in their areas. The functions of the LME include:

- Local business planning to ensure congruence with the State Plan;
- Governance, management and administration;
- Development of a community of qualified providers;
- Operation of a uniform local access system;
- Evaluation and continuous quality improvement;
- Financial management and accountability;
- Management of secure information systems with data on consumers, providers services and finances;

- Service monitoring and oversight, including provider compliance with standards, utilization and performance reviews;
- Technical assistance to providers.

LMEs enter into an annual Performance Contract with DHHS that define the responsibilities of the LME as a waiver lead agency and describe performance standards the LMEs are expected to meet.

North Carolina Department of Health and Human Services

Figure 1 (above) illustrates the Divisions within the Department of Health and Human Services (DHHS) involved in implementing the HCBS waiver, and describes each of their responsibilities.

- DMA delegates approval authority for the waivers to DMH/DD/SAS and the Local Management Entities (LMEs).
- DMH/DD/SAS has primary responsibility for implementing the QM procedures for the waivers at the state level. These responsibilities include:

    - Ensuring compliance with all state and federal audit requirements;
    - Collecting and managing all program and consumer data;
    - Researching and developing evidence based best practice models;
    - Supporting consumer involvement at all levels of the system;
    - Providing training and technical assistance to LMEs

- DMH/DD/SAS and DMA together are responsible for:
    - Oversight of contracts with Local Management Entities (LMEs);
    - Setting performance standards for LMEs;
    - Monitoring regulatory compliance with state, federal, and waiver requirements

CAP-MR/DD Waiver Quality Assurance Activities and Frequency of Activities

Quality Assurance activities begin at the local level with the individual, Consumer and Family Advisory committees, providers, case manager, and the LME. At the state level, activities are completed by the DMH/DD/SAS and DMA in the Department of Health and Human Services (DHHS).

Individuals will:
- Contact their case managers if they have concerns about their services or supports
- Access grievance and complaint processes, with assistance from their case managers, if needed, based on written materials provided by the LME

Individuals and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:
- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,

- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Provider Agencies will:
- Ensure that staff are qualified to deliver services and receive required supervision
- Monitor the provision of services
- Complete Incident Reports as required by DHHS rules
- Complete Death Reports as required by DHHS rules
- Contact the case manager if there are any concerns about the health or safety of the individual receiving services

The Case Manager will:
- Make a minimum of a monthly face-to-face visit with the individual to inquire about any concern or problem with service provision.
- Reassess each individual's needs at least annually and develop a revised person centered Plan of Care based on that reassessment.
- Follow-up and resolve any issues related to the individual's health, safety, or service delivery. Unresolved issues will be brought to the attention of the LME.

Local Management Entities will:
- Provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. Individuals will also be notified of grievance and complaint resolution processes.
- Resolve issues related to any individual's health, safety or service delivery that are unresolved by the case manager.
- Investigate complaints regarding licensed and unlicensed MH/DD/SAS providers as required by DHHS rules
- Oversee and monitor MH/DD/SAS services provided in the LME catchment area as required by DHHS rules inclusive of provider qualifications
- Receive and review Critical Incident Reports from MH/DD/SAS providers as required by DHHS rules
- Ensure that MH/DD/SAS providers complete death reports as required by DHHS Rules
- Ensure that reporting is made to the County Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that an individual may be abused, neglected or exploited and in need of protective services
- Complete and submit Quarterly Reports to DMH/DD/SAS, and the local Client Rights Committee to include the following:
- Incidents
- Complaints concerning the provision of public services
- •Complete and submit a report of monthly local monitoring activities to the Division of Facility Services and DMH/DD/SAS that identifies provider monitoring issues requiring correction and an explanation of uncorrected issues.

- Provide on-call emergency back-up through the LME to provide staff in the event that the emergency back-up strategies identified in the person centered Plan of Care cannot be implemented and there is potential that the person's health and welfare would be jeopardized.

The DHHS will complete:

- Monitoring of CAP-MR/DD providers. Monitoring includes yearly audits of paid claims to CAP-MR/DD providers. The sample used in determining the providers to be audited is chosen so as to offer statistical assurance of the overall performance of all CAP-MR/DD providers. In addition, providers with previous records of low performance are routinely included in the sample. The State undertakes reviews of local approval protocols for Plans of Care to assure interrater reliability. When there are out-of-compliance findings for any of these reviews or audits, Plans of Correction are required, and the State follows these plans with reviews to assure correction of system issues which contribute to out of compliance findings. Should corrections not be made, the option of suspension or revocation of a provider's privileges to bill is available.
- Investigations of incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the LME. If there are allegations of abuse, neglect or exploitation, a report will be made to the County Department of Social Services. Incidents and complaints regarding licensed facilities are investigated by or jointly with the Division of Facility Services.
- Track requests for reconsideration and resolutions of requests for reconsideration.
- Review Quarterly Reports of monitoring and incidents submitted by the LME.
- Track and investigate deaths of individuals. Deaths of individuals residing in licensed facilities are reported to the Division of Facility Services. Other deaths are reported to DMH/DD/SAS.

Quality Measures

The following table describes the Quality Framework domains that DMH/DD/SAS is currently using or will use to guide the measurement of system performance, both for CAP-MR/DD waiver and the MH/DD/SAS system.

Domain	Desired Outcome
Participant Access	Individuals have ready access to home and community-based services and supports in their communities.
Person Centered Planning and Service Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
Provider Capacity and Capabilities	There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights in accepting personal responsibilities.
Participant Outcomes	Participants achieve desired outcomes.
Participant Satisfaction (with system and processes)	Participants are satisfied with their services.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

Summary of Quality Management Measures

The following table summarizes the primary QM features according to the CMS regional review protocol components. These five categories are cross-referenced to the relevant HCBS Quality Framework domains. For each regional review category, the table also lists the key measures of performance that are used to ensure quality in each related domain. The table then summarizes how the Quality Management Plan operationalizes the CMS Quality Framework components of **Design**, **Discovery**, and **Remediation**.

The **System Improvement** component is not included in this table. Please note that the System Improvement component will evolve as a key part of the 3-year Quality Management Work Plan described earlier in this document. The Work Plan will develop the structure within which performance measures and other data will be managed to drive continuous system improvement.

CMS Regional Review Protocol Categories	Related HCBS QF Domains	Key Measures	Design	Discovery	Remediation
Level of Care	Participant Access	• Populations served • Timely Access • Notification of denial • Complaints • Service utilization and cost • Penetration rates • "Mystery Shopper"	• Access standards for timeliness • Eligibility criteria • Level of Care determination, and re-determination, standards	• Quarterly report from LME on access outcomes for all new service requests. • Monthly review of eligibility by DMA. • Quarterly monitoring by state Accountability Team. • Annual Medicaid Compliance Audit by DMA.	• Corrective actions required based on report results. • Fair Hearing process for consumers. • Technical assistance from LME
Plan of Care	Person Centered Planning and Service Delivery	• Informed choice about providers • Discharge planning and service coordination	• $ Allocations are based on historical data and prospective cost analyses • Person/Family-centered planning process • Standards for content and structure of plan.	• Case manager oversees and monitors development, implementation, and cost of plan • Contact standards for case managers • LME monitors service costs across all consumers, using Utilization Review Tool • Monthly, quarterly, and annual monitoring reports	• Case manager assures plan changes are made in partnership with consumer/family • LME responsible for consumer satisfaction
Qualified Providers	Provider Capacity and Capabilities	• Use of institutional care • Community service network	• Licensure and Certification (DFS)	• LMEs monitor providers according to performance contract with state.	• LME refers monitoring findings to appropriate state agency for investigation and

CMS Regional Review Protocol Categories	Related HCBS QF Domains	Key Measures	Design	Discovery	Remediation
		profile • Adherence to evidence-based best practices • Provider performance	• Provider criminal record checks • Provider standards (Provider enrollment process)		action • State and LME teams collaborate to analyze monitoring reports to ensure timely and appropriate correction of problems • State provides technical assistance to LME to support oversight.
Health and Welfare	Participant Safeguards	• Critical incidents • Medication management • Restrictive interventions	• Disaster Preparedness, Response, and Recovery plan • Emergency Plans and supplies • Policies on seclusion and restraint • Incident Response System • Complaint and Appeals process • State-level Consumer Services and Consumer Rights (CSCR) team • Client Rights Committees	• Incident response hierarchy assures timely and appropriate processing of incident reports • CSCR team analyzes data on complaints on state level • Client Rights Committees review incidents and complaints at LME level • Mortality reviews by LMEs	• LME uses incident response data to develop monitoring schedules and interventions. • CSCR team reviews all higher level incidents for LME and provider responses
Administrative Authority	• Participant Outcomes • Participant Satisfaction • System Performance	• Clinical outcomes • Personal outcomes • Community inclusion • Criminal justice involvement • Employment and school • Housing • Quality of life indicators • Satisfaction measures for Access, Appropriateness, Respect, Services and supports • Program financial integrity • Information system capabilities • Quality assurance monitoring • Utilization review • Quality improvement process • Participant and stakeholder involvement	• DMA Quality Assurance Program • Quality Management Plan • “Virtual Budget”, data-based allocation process	• Program data collected through MMIS and IPRS • Consumer data collected through CDW, DD-COI, and NCI. • Medicaid Compliance Audits • DMA Program Integrity Reviews	• Reports based on key indicators are shared with LMEs • Providers subject to paybacks and/or plans of correction for compliance audit findings • Program Integrity findings revealing fraud are referred to the Department of Justice.

Quality Management Plan - 1915 (c) Waiver

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

ATTACHMENT 1

Domain	Desired Outcome	Item	Status	Suggested Reporting Frequency
Participant Access	Individuals have ready access to home and community-based services and supports in their communities.	Services received (units, $)	Currently in use	Q
		Target populations served	Currently in use	Q
		Penetration rates	In development	Q
		Timely access	**In development**	**Q**
Person Centered Planning and Service Delivery	Services and supports are planned and implemented in accordance with each participant's needs, preferences and decisions about his/her life in the community.	**Discharge/after care planning and service coordination**	**Currently in use**	**A**
		Informed choice about providers	**In development**	**A**
Provider Capacity and Capabilities	There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.	**Utilization of state institutional care**	**Currently in use**	**Q**
		Distribution & types of community-based services	**In development**	**Q**
		Provider performance	In development	
		Availability of and fidelity to best practice models	In development	
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.	**Critical incidents**	**Currently in use**	**Q**
		Medication management	**Currently in use**	**Q**
		Restrictive interventions	**Currently in use**	**Q**
Participant Rights and Responsibilities	Participants receive support to exercise their rights in accepting personal responsibilities.	**Rights information (service denial notifications)**	**Currently in use**	**A**
		Complaints and appeals (# and types)	**Currently in use**	**Q**
Participant Outcomes	Participants achieve desired outcomes.	Clinical outcomes, improved function	Currently in use	A
		Community inclusion	Currently in use	A
		Criminal justice/Juvenile Justice involvement	Currently in use	A
		Employment/school	Currently in use	A
		Housing (independence and safety)	Currently in use	A
		Personal goals outcomes	Currently in use	A
		Quality of life indicators, well-being	Currently in use	A
Participant Satisfaction (with system and processes)	Participants are satisfied with their services.	Access	Currently in use	A
		Appropriateness	Currently in use	A
		Respect/courtesy	Currently in use	A
		Services and supports	Currently in use	A
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.	**Financial integrity**	**Currently in use**	**Q**
		Information systems and monitoring capabilities	**Currently in use**	**Q**
		Quality Assurance process (audits and provider monitoring)	Currently in use	Q
		Utilization Management/Review (high costs, denials or adjustments)	Currently in use	Q
		Quality Improvement process (local)	In development	A
		Participant and stakeholder involvement (CFAC)	**In development**	**Q**
		Quality Improvement process (state)	In development	

Bold items are included in the LME Performance Contract (along with other measures)
Frequency = Q (quarterly), S (semi-annually) or A (annually)

ATTACHMENT 2

System	Purpose	Status for Waiver Participants
Integrated Payment and Reporting System (IPRS)	Service utilization and claims data for state funds. The IPRS will be used to track, pay and report on claims submitted by providers for services rendered. Area programs/LME's will submit a single claim to the state, and the IPRS will process the claim from the appropriate funding source: Medicaid, Pioneer, CTSP and capitated risk contracts.	In use
Medicaid Management Information System (MMIS)	Service utilization and claims data for Medicaid funds	In use
(HEARTS) Healthcare Enterprise Accounts Receivable and Tracking System	Billing system used for state operated facilities. Service utilization and consumer descriptive and outcomes information for state operated facilities	Applies only to individuals in state institutions
Client Data Warehouse (CDW)	Consumer demographics and descriptive information	In use
Decision Support Information System (DSIS)	Integrated consumer data from other data sources	In development
Automated Incident System	Consumer-specific information on deaths, abuse, restrictive interventions, and other incidents	In development
National Core Indicators (NCI)	Consumer outcomes and satisfaction information	In use
Developmental Disabilities Consumer Outcomes Inventory (DD-COI)	Consumer outcomes and satisfaction information	In use (to be replaced by NC TOPPS)
Olmstead Outcomes	Consumer outcomes and satisfaction for Olmstead populations	In use
NC SNAP	Assessment tool for DD populations	In use
NC TOPPS	Web-based consumer outcomes and satisfaction information	In development
MMIS+	Integrated service utilization and claims data for state and Medicaid funds	Planned
Health Information System (HIS)	Integrated DHHS information system	Planned